

THE PROPHYLAXIS
OF
MENTAL DISORDER

RELATED TO
CHILDBIRTH

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I N T R O D U C T I O N .

Childbearing, although a normal physiological process, has never become one that is free from all hazard, nor without major tragedies.

Improved techniques, and antibiotic drugs have lessened the possibility of infection or obstetric disasters. Adequate ante-natal services have made possible the early recognition of pathological processes, and have been the means whereby cases likely to have special difficulties in delivery could be selected and given detailed care and attention, in hospital and during labour.

It seems a pity that less progress has been made in providing help for the psychological and social difficulties of the childbearing woman. Much has been written about the mental illnesses which these women develop through lack of such care, but little seems to have been done from a practical point of view to rectify the situation. The attitude towards mental disorders associated with childbirth appears to be that of fatalism, and obstetric almoners are encouraged to offer reassurance and help along the lines of "this is a normal process so there is nothing to worry about". If urgent social and other problems are forced upon them by the patient, then the procedure is to deal exclusively with the immediate problem, without consideration of whence it arises nor what repercussions or ramifications it may have. Nor is there any attempt made to assess the personality of the individual concerned so that no true idea of what the particular

difficulty means to this woman is possible.

The length of hospitalisation for those who do succumb, regardless of whether the process of childbirth in itself is considered the causal agent, or whether it may be just one of a series of possible precipitating factors, seems to make it worth while to do something more active in prevention of such mental illnesses. Surely the separation of mother and child so early may have adverse effects on both, to say nothing of the financial and other repercussions on the husband and any other children of the family group. It seems therefore essential to avoid altogether such a situation as this wherever possible.

This study was therefore undertaken in an attempt to assess the possible factors leading to mental illness following childbirth, and to suggest practical means of prophylaxis.

H I S T O R Y.

Mental disorder occurring as a complication of childbirth was recognised and described as far back as almost the beginning of medicine itself. Hippocrates, Celsus, Galen and Soramus recorded instances of post-partum psychosis. Hippocrates believed that these were due to, either suppressed lochial discharges, a diversion of the milk from breast to brain, or from the influx of blood to the breasts, and the bleeding from the nipple of a woman recently delivered was a possible precursor of mania. Daniel Sennert (1572 to 1637) thought that puerperal mental disorder was caused by vapours arising from the uterus to the brain. Throughout the 18th century the search for specific causes which would make the puerperal psychoses a clinical entity continued. In 1768 Planchon again related these mental disorders to suppression of milk secretion or of lochial flow. In 1784 Rasher expressed much the same views.

At the beginning of the 19th century Levret thought that he could observe particles of milk in the brain of a woman who died whilst suffering from puerperal psychosis. Many writers at this time thought that between the tenth and twelfth days after childbirth that deposits of milk formed in the brain, leading either to compression or distention of the nerve fibres and causing psychosis. Esquirol subscribed to this belief and that the sex of the child might have some bearing on the case. In 1847 James Macdonald studied 66 cases of puerperal insanity. He

grouped them according to the development of mental disorders during pregnancy, parturition or lactation and also separated them into an acute and chronic group. The forms of mental illness were given as mania, monomania and dementia, but he still clung to the belief that there was something specific about the mental illnesses occurring in the puerperium and stated that the acute form of mania could be distinguished from "other forms of madness", by various points including the gross obscenity which he attributed to the disturbed uterine function. He did not believe in the old ideas that suppression of milk had aetiologic significance, and pointed out that autopsies on such cases failed to reveal milk in the cranium or abdominal cavity. He thought, however, that there was a milk diathesis during lactation and that this produced a susceptibility to puerperal insanity although he felt in some cases that the disease originated in the reproductive organs. He recommended as treatment, blood letting for cerebral congestion, emetics, warm baths, wine, blisters, emmenagogues and the like. In England at about the same time John Connolly was recommending much the same sort of curative measures.

It was not until 1858 that the first real attack came on the ancient views that there was a specific form of insanity in the puerperium. At that time Marcé stated that the psychoses occurring at this time were in no way different from psychoses occurring in non-puerperal women of the same age. His observations were nevertheless disregarded and between 1860 and 1900

the literature is filled with case reports on "puerperal insanity" which, as in the case of Macdonald in 1847, was further subdivided into insanities of pregnancy and lactation and puerperal insanity. In 1890 Olshausen is quoted as having divided these psychoses into three groups - toxic, infectious and idiopathic. The nomenclature used during this period was supposedly based on aetiologic considerations so that the psychoses of gestation were due to anaemia, albuminuria, physical exhaustion, domestic unhappiness and fear of childbirth; those of the puerperium due to pain shock, infection and haemorrhage, and those of lactation due to exhaustion, anaemia, and depletion by prolonged nursing. The predisposing cause for all types was primarily neuropathic heredity but poor mental and moral training and illegitimate pregnancy were also considered significant. From 1900 to 1915 the literature is concerned with the reclassification of puerperal mental disorders into the regular scheme of psychiatric diagnosis and shows that there is no specific mental disorder which occurs in relation to childbirth.

From 1915 onwards many papers have been written, which deal with treatment, prognosis, and possible precipitating causes of these mental disorders, and a few in more recent years have attempted to suggest means of prophylaxis. The relevant papers written within the last thirty years will be considered in this thesis, under the appropriate sections.

REVIEW OF INCIDENCE AND PROGNOSIS OF MENTAL
DISORDER RELATED TO CHILDBIRTH.

Zilboorg in 1928 stated that puerperal psychoses were not uncommon and quoted a number of authors to show the various figures for the incidence of psychoses amongst the childbearing population and also the porportion of psychoses due to childbearing causes of the total female admissions to mental hospital. He says that de Forest found one psychosis in every four hundred confinements and tabulates the reports of a number of other observers. The conclusions that he draws are that 8.7% of a total of 10,000 psychotic women belong to the puerperal group. He says that the figures for the State of New York amounted to 3.4% of the total of first admissions to the State Hospitals and suggests that the contrast between the two figures may be partly accounted for by the fact that the data for the New York State Hospital estimates, cover only first admissions. He also notes that statistical study of puerperal psychosis shows that childbirth is the most critical factor in the precipitation of mental disorder during the reproductive period. Of all mental disorder related to gestation and childbirth 3% to 23% occur during pregnancy, whereas 6% to 45% occur during lactation, while in the puerperium the figures are higher, being 40% to 86%. He also points out that it should be taken into consideration that a slowly developing psychosis which may appear to be related to the lactational period may well have started during the puerperium, thus making the figures for the incidence

of mental disorder even higher during the puerperium. He includes the following tables in his paper which will be printed here in order to show the findings on the incidence of mental disorder related to the reproductive period up to the time when his paper was written in 1928.

TABLE 1. INCIDENCE OF PSYCHOSES RELATED TO PREGNANCY, CHILD BIRTH AND LACTATION.

Observers or Hospitals.	Number of women admissions	Number of psychoses related to PR, CH, & LACT.	PER CENT.
Tedler	889	70	7.8
Glasgow Asyl.	316	25	7.9
Leidesdorf	200	20	10.0.
Holm	1063	143	13.4
Leubben	4184	181	15.3
Charite	508	86	16.8
Ripping	780	168	21.6
Hoche	2454	211	8.6
TOTALS	10394	904	8.7

TABLE 11. NEW YORK STATE HOSPITALS' FIRST ADMISSIONS (WOMEN)

YEAR	ADMISSIONS	PUERPERAL CASES	PER CENT.
1916-17	3272	122	3.7
1917-18	3267	119	3.6
1918-19	3264	94	2.9
1919-20	3209	123	3.8
1920-21	3274	102	3.1

He does not, however, include the findings of Kraepelin nor of Clouston. The former stated that these cases constituted 7% of female admissions to mental hospitals, while the latter gave the figure as 5%.

TABLE 111. INCIDENCE OF PSYCHOSES DURING PREGNANCY,
PUERPERIUM AND LACTATION.

Observers or Hospitals	No: of Cases	% for period of preg- nancy	% for period of puer- perium	% for period of lact- ation.
(Vienna	140	21.4	70.0	8.6
Anton (Graz	66	9.0	45.5	45.5
(Halle	111	9.6	61.4	29.0
Ashaffenburg	132	22.7	57.6	19.7
Behr	100	3.0	77.0	20.0
Furstner	34	14.7	61.7	23.6
Gundry	56	12.5	51.8	35.7
Henwell	43	9.3	60.5	30.2
Herzer	221	21.2	47.0	31.8
Hoche	211	11.3	44.0	42.1
Holm	145	17.9	40.0	42.1
Macdonald	66	6.2	66.0	27.2
Marcé	79	22.8	52.0	25.2
Menzies	140	21.4	45.7	32.0
N.Y. State Hospital				
1919-21	225	14.2	78.6	6.4
Quensel	112	16.7	45.5	25.0
Ripping	168	19.0	53.0	28.0
Siemerling	332	3.0	86.0	10.0
Tuke	155	18.0	47.2	34.8

He also states in this same paper that the malignant type of puerperal psychosis is frequently met with and quotes Quensel, as having said that more than half these cases failed to recover while 24% of Strecker's cases, he says, belonged to the schizophrenic group, and Hoppe noted the failure to recover in 36%, while Aschaffenburg said that 47% failed to recover, so that roughly speaking one-quarter to one-half of the cases Zilboorg felt showed a malignant reaction.

Since Zilboorg's paper other authors have commented on the incidence of psychosis during the reproductive period. In 1934 Frumkes noted that the incidence of puerperal psychosis was 1/1000 of all deliveries and 3.8% of all psychoses occurring in women. In a paper written by Karnosh and Hope in 1937 they compare the incidence of childbirth psychoses to the number of births and to all types of psychoses developing in a ten-year period and could show no fixed constancy of puerperal psychosis as compared to the birth rate or total psychotic population. They have therefore postulated, that other factors were involved, besides constitutional predisposition on the part of the patient to develop certain types of psychoses under severe physiological strain; and noted, that toxic, endocrine, and emotional factors were all implicated as the additional factors by various authors.

McGeorge in 1938 quotes Jellett as saying that mental illness in the puerperium constitutes 5% of all mental disorder occurring in women, while mental disease in pregnancy constitutes 1 - 2% of all mental disorder in women, and in lactation 3 - 4%. McGeorge himself notes the incidence of mental disorder occurring in relation to childbirth as being 1/400 to 1/500 confinements.

In May 1938 Philip Piker quotes various writers as giving the incidence of psychosis associated with childbearing as 1/400 to 1/1192. He gives the

average of the different ratios cited for Queen Charlotte's Hospital, the Rotunda Hospital Dublin, Ireland generally, and elicited by de Forest, Langdon, Frumkes, Armstrong-Jones and Partridge as 1/858. Piker goes on to say that although the percentage incidence of slightly more than 0.1% seems hardly enough to merit consideration, nevertheless, as he says, and as Boyd in 1942 later pointed out, these figures represent, for the most part, only those patients who were sufficiently abnormal mentally to have been noticed by the non-psychiatric observer. He also makes the same point as Zilboorg in May 1928, that a good many of the so-called psychotic developments of pregnancy, do not manifest themselves until some time after delivery so that the connection may not be recognised. There is, of course, in addition to these two factors the point that there are probably many slightly less acute and more transient mental upsets which are over so quickly that they never reach the psychiatrist and all these points probably mean that the total incidence is somewhat higher than the figures given. Piker also looking at the situation from a somewhat different angle quotes Cole as saying that 7.5% of all female psychoses are associated with reproduction. Stones and Karnosh, he says, found a similar association in 5.5% in 1,604 psychotic women. He comes to the conclusion that almost 9% of all females who suffer from psychosis of various sorts develop their mental disorders in connection with the

the reproductive experience. He sums up by saying that "when we recall the 9% contribution of pregnancy to the total psychoses in females and in the light of the fact that the incidence of psychosis among pregnant women is almost twice that among the female population generally, we cannot but feel that pregnancy and its implications may provide distorting influences that are more intense than women ordinarily are called upon to face".

Cruickshank in 1940, discussing the incidence of psychosis in women, states that the percentage that occur in relation to childbirth vary from 2 to 20%, in all the estimates that he has been able to trace, but notes that the bulk of statistics set the figure at 3% and that the chances of a woman becoming psychotic with childbirth are about 1/1,000 confinements.

In 1940 John Smalldon thought that the incidence of puerperal psychosis was rather higher in the Jewish part of the population. In 1941 Kraines stated that the incidence of postpartum psychosis was 1/400 to 1/1000 in comparison to the incidence of psychosis in the general population which he quoted as being 1/1000. For this reason he thought that pregnancy was only a precipitating factor.

In 1942 Ian Skottowe stated that the incidence of puerperal psychosis was 1/1000 of childbearing women, and Hinson in the same year gave the incidence as 1/400 to 1/500 deliveries, at the same time stating that 9% of all female admissions to mental hospitals were

puerperal psychoses.

In 1943 Von Hagen stated that mental disorder occurring in the reproductive period constituted 5 to 10% of all psychoses occurring in women, and also in 1943 Schmidt gave the incidence as 1/400 to 1,000 deliveries and 10% of all female admissions to psychiatric hospitals. Also in the same year Stewart noted that the incidence of psychosis in pregnant women was twice as high as for that of the female population generally. More recently Chapman in 1947 has noted that the incidence was 4.5% in 1,948 mental hospital admissions.

Although from all these figures it would seem that opinions vary fairly widely upon the incidence of psychoses occurring in relation to childbirth, the fact that Stewart in 1943 thought that it was twice as high as in the general female population, and Kraines in 1941 noted that it was possibly more than twice that occurring in the general female population, seems to point to the fact that childbirth itself plays a part at least as a precipitating factor in this illness.

PROGNOSIS.

Since Zilboorg's paper in 1928 in which he stated that almost half the cases did not recover, various other authors have commented on the prognosis in mental disorder related to childbirth. In 1935 James stated that 8% of these cases die, that 20% become chronic mental hospital inhabitants, while 70% recover. He added that the 70% whom he thinks recover may well "live in the shadow of recurrence"

after suffering an illness of some months' duration.

Harris in 1936 stated that the prognosis in these cases deteriorates in every successive psychotic illness occurring in relation to childbirth.

Karnosh and Hope in 1937 noted that the prognosis was bad in those patients with a schizo-thymic personality.

Piker in May 1938 stated that the prognosis in these cases was generally good and that figures given by various clinicians range from 70% to 53% recoveries. Of the 719 cases in his survey he states that 65% terminated favourably, not including deaths. As he points out, the cases that he studied were State Hospital patients and that therefore one might assume that they represented the least favourable group prognostically, so that the figures might be more optimistic even than he indicated. However, from the point of view of duration of the disease, in 283 cases which recovered the average duration of the psychosis was six months. That was excluding thirteen of his cases which remained psychotic for approximately eight years each and therefore influenced the duration time adversely. He, like other writers, points out that the schizophrenic types offer a worse prognosis although it is better than in schizophrenia generally.

Cruickshank in 1940, in his group of 84 cases, sub-divided them into toxic exhaustive, manic depressive and schizophrenic groups and considered the prognosis in the three groups separately. The duration of the

psychosis in the toxic exhaustive group varied from 3 - 9 months with an average in the three groups of ten weeks. In the manic depressive group the majority made an uneventful recovery and the average duration of illness in recovered cases was four months whereas in the schizophrenic group the course was long and the prognosis poor. Out of a total of 22 schizophrenic cases only 5 had full remissions and 5 had social remissions. The outcome in the others was unfavourable generally speaking and the average duration of illness in recovered cases was a year. He pointed out that all his cases of schizophrenia with onset during the gestational period were still in hospital after periods of from 1 - 9 years and that there had not been one recovery.

Kraines in 1941, although he did not give figures for the recovery rate, stated that the prognosis depended upon four factors, the presence or absence of toxic-infective factors, the amount of disturbance in the underlying personality before pregnancy, the promptness with which shock therapy is instituted and the adequacy of subsequent psychotherapy.

In 1942 Ian Skottowe stated that schizophrenic illnesses occurring at this time rarely recovered whereas the affective disorders recovered in 3 - 6 months. Also in 1942 Ordway and MacIntyre, although not giving figures for the prognosis, said that it depended upon constitutional predisposition and was related to the personality make-up and precipitating factors.

Hinson in 1942, noted that the prognosis was worse in those with previous breakdowns or bad heredity, and disagreed with other authors who said that the later in pregnancy the illness appeared the better the prognosis.

Chapman, in 1943, thought that those with manic depressive features outstanding, recovered almost invariably while with schizophrenic features present they generally did not recover. This author did not think that toxic features changed the prognosis and that high temperature could be observed in the beginning of schizophrenic as well as manic depressive psychosis, but postulated that environmental factors seemed to play an essential part in the production of these psychoses and that changes in the environment or good ability of the individual to adjust herself, were necessary for a good prognosis.

Von Hagen in 1943 thought that the prognosis was poor unless the cases were properly treated early, while Jacobs in the same year stated that the prognosis was good, 17 out of her 21 cases recovering. It is to be noted that her cases were mainly depressive illnesses.

In the same year Schmidt stated that the prognosis in these cases was good. Stewart also in 1943 in contradiction of Hinson in 1942, felt that the prognosis was worse, the later in pregnancy or the longer after delivery it occurred. Cohen in 1943 stated that over-dependence or hypochondriasis led to a prolonged puerperium.

Chapman, in 1947, felt that the prognosis depended

on the previous degree of personality integration and the future environment.

To sum up what has been said regarding the prognosis in illness occurring in relation to childbirth, it would seem that it is mainly the schizophrenic illnesses which carry such a bad prognosis and most authors state that almost invariably there is no recovery from them. On the other hand the prognosis seems to be good in the manic depressive type of disturbance but even with affective disorders it may take 3 - 6 months for a recovery to take place. Although these are very general statements, other authors more recently have drawn greater attention to the importance of the previous personality, to the environment and to the constitutional factors. It seems, therefore, that even where the prognosis may be considered quite good, that a long period of hospitalisation will be necessary, and furthermore, if the environmental factors are adverse or there is a poor constitutional make-up, that ultimate recovery may still not be complete. It is in view of these findings on incidence and prognosis in this type of illness that it was thought essential to study the present series of cases in this thesis from the point of view of constitution, of the previous personality, and possible precipitating factors in the environment, so that reasonable means of prophylaxis might be suggested to avert at the worst an irrecoverable illness, or at the best, a prolonged period of hospitalisation.

THE OBJECTS OF THE PRESENT INVESTIGATION AND THE
APPROACH TO BE USED.

That there is no psychosis specific to the childbearing period was first shown by Marcé in 1858. Although his views were completely disregarded for the next fifty years, by 1900 they appear to have become more widely accepted. From 1900 onwards many writers have reaffirmed this point of view, among them Clarke 1913, Kilpatrick and Tiebout in 1926, Frumkes in 1934, McGeorge in 1938, Smalldon in 1940, Hinson and Ian Skottowe in 1942, Jacobs in 1943 and La Loggia in 1947.

In spite of the fact that there seems to be such complete agreement that there is nothing specific about the types of illness which occur in relation to childbirth, there is perhaps less uniformity of opinion regarding the reasons for breakdown at this time at all. Many authors feel that the metabolic upheaval of pregnancy and parturition in itself is the chief precipitating cause and most admit that something more must be superimposed to explain the fact that not all women become mentally ill in relation to childbirth. Some have suggested that toxicity, sepsis and exhaustion might be the added factor, and in 1937 Karnosh and Hope stated that the only characteristic element in these illnesses was delirium. This was in keeping with the views of Strecker and Ebaugh who in 1926 noted that there was a severely disturbed sensorium in 77% of the manic-depressive cases and that the index of hallucinosis was three times that occurring usually in manic-depressive illnesses.

In 1940 Smalldon noted delirium in only 3.6% of his cases and found the clear cut depressive illnesses to be predominant. Ian Skottowe in 1942 again contradicted this newer view-point by stating that in his cases confusion was six times as common as in non-puerperal psychoses and formed nearly half the psychoses associated with childbirth. Jacobs in 1943 corroborated Smalldon's views and contradicted Skottowe and earlier writers by saying that not one-third of her cases showed delirium and catatonic features which would be expected if toxic exhaustive factors were important. More recently La Loggia in 1947 noted that in the lactational period, either confusional, schizophrenic, or depressive pictures might occur while in pregnancy and the puerperium confusion or depression were more common. He did not, however, make it clear that he felt that confusional cases occurred with any more frequency than clear cut depressive illnesses.

It would seem therefore, that although there has been a good deal of controversy on this score that on the whole more recent writers do not seem to consider that delirium or disturbance of the sensorium is any more frequent in mental illnesses occurring in relation to childbirth, than those occurring at any other time. This would favour the supposition that sepsis, exhaustion, and toxæmia do not play a very vital part in the production of these illnesses. Also in keeping with this is the fact that many women who have

septic puerperia, toxæmia of pregnancy, etc., do not all develop a mental illness.

Once again therefore one is left to presuppose that there are additional factors which may be responsible. At this point many authors, especially those writing during the last ten years, have tended to follow the same lines of thought. The heredity, the previous personality, and psychological and social factors have all come under suspicion. The findings of the various authors will be considered under the appropriate headings in this thesis, but one may sum up by saying that on the whole although an admixture of all three factors in varying proportions are usually considered to be responsible, few conclusions have been drawn whereby preventative measures might be established.

The purpose of this thesis therefore was primarily to reassess the relative importance of each of these factors and from this reassessment to attempt to put forward means of prophylaxis. The approach to be used had of necessity to be based on a study of abnormal cases owing to the reluctance of maternity hospitals to permit psychiatric case taking on any of their normal cases. For the same reason normal controls for the present series of abnormal cases could not be provided. The number of cases studied was too small to allow of any statistical investigations, but this was unavoidable owing to the limited number of cases of this type admitted to hospital and the impossibility of supplementing them widely from old cases

in the records because of the inadequacy in many instances of necessary material.

The approach used to these patients' problems in this thesis was a psychobiological one and it was felt that the Meyerian doctrine that "the study of the total behaviour of the individual and its integration, as it hangs together as a part of a life history of a personality," was the one most likely to show clearly where the important difficulties lay for each individual.

No attempt was made to classify the cases as "puerperal", "lactational" or "pregnancy" mental disorders as the division seemed to be unsuitable

for the purpose of this thesis, and it was felt that no hard and fast line could be drawn between them. Cases whose mental illness appeared to have dated from the onset of pregnancy up until one year after delivery have been included. This is perhaps permissible in view of the fact that there seems to be agreement that abnormal behaviour occurring within a year of childbirth may still be related to childbirth. This is illustrated by the legal stand point, where a considerable difference is made by the law between criminal behaviour occurring before and after a year following childbirth.

THE METHODS OF INVESTIGATION OF CASES.

The patients were admitted and treated according to the ordinary routine of the hospital, and were discharged and disposed of according to their needs, although a certain number of the cases are still under treatment in hospital at the time of writing.

The form of case taking was on a common plan as follows:-

- (1) The reason for referral.
- (2) The family history, paying particular attention to the parents and siblings and any history of mental disorder, also abnormal or maladjusted parental situations which might have created an unsatisfactory early home background for the patient.
- (3) The complete personal history of the patient from infancy onwards, including previous mental and physical health.
- (4) The personality previous to the illness.
- (5) The history of the present illness.
- (6) The patient's condition on admission including the physical and mental state.
- (7) The patient's further progress in hospital.
- (8) The diagnosis.
- (9) Progress after discharge if known.

The case histories detailed in this thesis were written on this plan and included all relevant facts in a slightly abbreviated form. The full clinical records would be of too great length for this purpose. The routine case summaries on the other hand, would not be sufficient, as in this study a Meyerian approach has been adopted and each patient considered as an individual within its own constellation of life situations. Special emphasis has been laid on aspects

of the patient's life which may have a bearing on the present breakdown.

The main purpose of this thesis was to assess the importance of difficult life situations in the production of mental illness following childbirth, taking into account the heredity and the personality of the individual. In this way it was hoped to indicate possible lines of prophylaxis.

From the abbreviated case histories the information required to achieve these objects was first extracted and listed into the following main groups for the purposes of analysis, as described below:-

(1) HEREDITY.

- (a) Those members of the family in the same or previous generation who were sufficiently ill to be admitted to a mental hospital or treated by a psychiatrist at any time in their lives.
- (b) Those parents who showed drunkenness psychopathy, marked mood variations, or other minor personality disturbances.

(2) UNFAVOURABLE CIRCUMSTANCES IN THE PATIENT'S EARLY HOME LIFE.

- (a) Maladjustment of the parental marital situation.
- (b) Abnormalities of the parental situation such as step-parents, etc.

(3) PREVIOUS PERSONALITY OF THE PATIENT.

- (a) This could not be studied in detail and only the broadest conclusions as to the stability or otherwise of the patient can be drawn from this part of the work, as no set scheme has been used but rather common traits have been picked out and assembled from all the histories.

The main aspects studied will be noted under the section on the analysis of the previous personality.

In the first place many more features of these patients' previous personalities were analysed but discarded as not appearing with sufficient frequency. In spite of taking only those which seemed to be present in a fairly large proportion of cases, the total number of cases was too small to draw any very definite conclusions.

- (4) LIFE SITUATIONS, - which appear to have disturbed the patient at the time of the present pregnancy and delivery, whether they have been operative only immediately prior to and during this period, or whether they have been operative for a longer time but appear to have a cumulative or direct bearing on the patient's present breakdown. In this section the cases have been divided into two groups, the multiparae and the primiparae. It was felt that although no actual control group of cases has been used, that the multiparae controlled themselves in a sense, as they had all had previous opportunities to break down following childbirth. Some in fact had done so, others had not, so that it was felt that a close study of these cases might possibly show why this was so. Also, if in fact difficult life situations played a part in their breakdown, then there should be some evidence of change in the life situations between pregnancies with puerperal breakdowns and those without. With this in mind the multiparae were further subdivided into three groups:-
- (a) Multiparae without previous puerperal breakdown.
 - (b) Multiparae with previous puerperal breakdowns and previous normal pregnancies.
 - (c) Multiparae with previous puerperal breakdowns in all previous pregnancies.

It was further felt that if reasons could be found for the occurrence of breakdowns in some pregnancies and not in others, then it was there that lines of prophylaxis might present themselves more than anywhere else.

The primiparae were considered separately as it was thought that they might present a much more clear cut picture, which would offer better

possibilities of studying precipitating factors and again suggest lines for prophylaxis.

Also considered under this section were any mental breakdowns that these patients had had which were unrelated to childbirth. These were further subdivided into those occurring prior to childbirth and those after childbirth. The relationships of these breakdowns to attitudes concerning marriage, future childbirth, etc., were further analysed.

The last point to be considered in this section was the presence or absence, during the actual mental illness related to childbirth, of trends which seemed connected with any difficulties in life situations, and which could therefore be considered as stressing the importance of these difficulties in producing the present breakdown.

(5) PROPHYLAXIS.

The last section is mainly concerned with measures which might be adopted in order to prevent mental breakdowns in relation to childbirth, taking into consideration the facts which had been extracted from the previous four sections.

THE MATERIAL.

The material for this thesis consists of all the cases of mental disorder related to childbirth that were admitted to the Bethlem Royal Hospital between June 1949 and November 1949. Two of them were not, in fact, at the time of the present admission, suffering from an illness related to childbirth, but had done so previously.

Owing to the fact that the total number of cases seen was only 18 it was felt that this group in itself was insufficient. In order to supplement the case material therefore two cases were added which had been under the author's personal care at the Maudsley Hospital in 1948 and five other cases were taken from the records of the Maudsley Hospital, three of them belonging to the year 1949 and two to the year 1946, thus bringing the total number of cases up to 25. Previously an attempt had been made to utilise all the case material which could be extracted from the records of the Maudsley Hospital but owing to the war years and the inadequacy of the case notes at that time, it was felt that to use this material would have been impracticable. Also it would have been impossible to obtain confirmation of the facts in those case notes from relatives who, during the passage of time, might well have moved out of the London area.

The five cases which had not been under the care of the author were drawn at random from the case records, being chosen merely because they had been studied more fully.

As has already been stated, two of the total number of cases were not suffering at the time of the present admission from an illness related to childbirth, one of them being a woman of 59 who had an involutional depression but had had a puerperal breakdown in her first pregnancy and was able to describe in some detail her feelings and difficulties at that time. In the case of the second one the present admission was the second time that she had come into hospital following a puerperal breakdown, but on these two subsequent occasions the breakdowns were unrelated to childbirth. She, too, was able to give a good account of her puerperal breakdown and was also included in this series for that reason.

The ages of the patients range from 20 to 59 in the case of the woman suffering from the involutional depression who had previously had a puerperal breakdown. Excluding her, the eldest patient in the group was aged 45. Most writers on mental illness related to childbirth usually sub-divide the cases according to whether the illness started during pregnancy, the puerperium, or the lactational period. In the 25 cases studied in this thesis, it was felt that such a division would be unnecessary. The time of onset has in fact been noted in each case

in relation to the delivery date, but in analysing the cases as a group, the material will be considered under the general heading of 'Mental Illness Related to Childbirth'. In fact some of these cases started during pregnancy, others during the puerperium and the rest following delivery. The whole group range, in the time of onset of their illness, from between the 2nd month of pregnancy to the 11th month after delivery. In accepting the case which started 11 months after delivery as one of this group, the legal criterion of mental disturbance associated with childbirth in relation to infanticide, was used.

All the cases were closely observed over the time of their in-patient treatment and the majority of them were followed up for varying periods. Some, however, were still in hospital at the time of writing.

Considerable and detailed care was taken over their histories which were confirmed from near relatives. The help of psychiatric social workers was used wherever necessary, with visits to their home surroundings. Thus was ensured the accuracy of detail necessary for an investigation where aetiology was under examination. The number of cases is a small one, but owing to the inadequacy of earlier records, it was felt that only in this group of recent cases could one be certain of ascertaining sufficient and reliable enough facts. A control group of women passing normally through pregnancy and delivery would have been helpful but for two reasons this has not been used. Firstly it was felt that the Meyerian approach, using

a study of the total individual as a psychobiologic unit was preferable, and as no two individuals and their life situations could be identical, this method cannot make use of controls. Secondly the difficulties of obtaining a control series of normal pregnant women under present circumstances would have been considerable. The Almoner of a large teaching hospital was approached but the attitude that has already been mentioned of "letting sleeping dogs lie" meant that the case records would have been quite inadequate from the point of view of this thesis, and there was a certain reluctance to allow these patients to have a psychiatric interview. This total, however, although of small proportions, could be considered of value owing to the care taken to ensure accurate detail of the case material and because few papers written on this subject include detailed case histories.

Out of the total group of 25 cases, 14 were multiparae and 11 primiparae. They came from widely different social conditions although the majority were from ordinary working class homes (16 cases). The other 9 cases were all quite comfortably off. Most had their homes in the London area although one had come from Scotland for her delivery, another had been delivered in Venezuela and her home was in Chester, and three more came from the Home Counties. The early backgrounds in a few cases were widely different. One patient was Dutch and had spent most of her life up to the time of her marriage in Holland. Another patient was German

and had had to leave her own country some 15 years previously for political reasons and one, already mentioned, although brought up in this country, had lived throughout her married life in Venezuela.

There was only one illegitimate pregnancy in the whole series of 25 cases.

The patients had been admitted from a variety of sources, some straight from maternity hospitals but more often having been referred by their own doctors to the Out-patient Department of the Maudsley Hospital. A few with more acute onset had been admitted from St. Francis Observation Ward.

They were all voluntary patients and none had been certified, but apart from that, there was no special choice of case for the purpose of this thesis.

CLASSIFICATION OF CASES IN REGARD TO PARITY
AND DIAGNOSIS.

P R I M P A R A E.

<u>CASES</u>	<u>DIAGNOSIS</u>
Case No: 1.(A.V)	Depressive Reaction with Anxiety Features.
" " 2.(I.M)	Depressive Reaction with Anxiety Features.
" " 3.(R.W)	Depressive Reaction with Anxiety and Obsessional Features.
" " 4.(E.H)	Depressive Reaction with Hypochondriasis.
" " 5.(J.S)	Mixed Affective Reaction.
" " 6.(M.H)	Mixed Affective Reaction.
" " 7.(S.R)	Schizo-affective Reaction.
" " 8.(J.W)	Schizo-affective Reaction.
" " 9.(M.D.H)	Schizophrenic Stupor.
" " 10.(B.E)	Periodic Catatonia
" " 11.(M.J.C)	Acute Schizophrenic Reaction.

CLASSIFICATION OF CASES IN REGARD TO PARITY

AND DIAGNOSIS.

M U L T I P A R A E.

CASES

DIAGNOSIS.

Case No:	12	(M.C)	Depressive Reaction.
"	"	13 (M.A)	Depressive Reaction.
"	"	14 (M.B)	Depressive Reaction.
"	"	15 (E.D)	Depressive Reaction.
"	"	16 (E.L)	Depressive Reaction.
"	"	17 (R.E.W)	Depressive Reaction.
"	"	18 (R.H)	Depressive Reaction with Anxiety Features.
"	"	19 (V.P)	Depressive Reaction with Anxiety Features.
"	"	20 (M.L)	Depressive Reaction with Anxiety Features.
"	"	21 (A.K)	Depressive Reaction with Hypochondriasis.
"	"	22 (A.S)	Depressive Reaction with Paranoid Features.
"	"	23 (W.S)	Mixed Affective Reaction.
"	"	24 (N.C)	Schizo-affective Reaction.
"	"	25 (F.H)	Anxiety Reaction.

STUDY OF THE MATERIAL.

FAMILY HISTORY.

Various authors have mentioned the importance of the family history in the production of mental illness in the puerperium.

As has already been noted in the historical review, the inheritance came under consideration even in fairly early days of study of these conditions, but since 1915 other authors have made reference to it. In 1924 Bourne stated, that 27% of cases suffering from puerperal illness had a positive family history, but did not go into more detailed consideration of the matter. In 1926 Kilpatrick and Tiebout, in analyses of their cases, noted that those which they classified as the non-toxic delirial types, showed a more positive history, especially in comparison with their toxic delirial group. McGeorge in 1938 stated that there was frequent neurosis evident in the family histories and Hayworth in 1939, in studying a total number of 117 cases suffering from mental illness during the puerperium, noted that 36 of the total number of cases showed near relatives with insanity, epilepsy or alcoholism.

Cruickshank studied 84 cases in 1940 of whom 32% had a neuropathic ancestry taking into consideration frank psychoses, neuroses, epilepsy and chronic alcoholism. The highest incidence of tainting was in the manic-depressive group and lowest in the toxic-

exhaustive cases.

In 1940 also Smalldon, in an extremely good paper which reviewed the literature up until that time, stated that the family history was worse in the manic-depressive group of his cases and in 1943 Jacobs agreed that the family history was of importance mainly in this same group. In 1942 Hinson said that neurotic and psychopathic taint was common in cases of pregnancy psychoses which he studied. Ordway and MacIntyre, also in 1942, studying 45 cases of puerperal mental illness, stated that in 16 out of 27 primiparae and 12 out of 18 multiparae the family histories were negative. Ian Skottowe in 1942 noted that there was a hereditary^{pre-}disposition in a half of the total number of cases studied by him, but was not more specific as to the exact nature of the hereditary taint. La Loggia in 1947 stated that there was a neuropathic or psychopathic inheritance in schizophrenic cases occurring in the puerperium. Various of these authors have quoted other references, among them Canon and Hayes who also noted a neuropathic and psychopathic taint of 50% of the cases. Fishback noted 45.5% taint in the family history and 38% who were frankly psychotic and De Lee stated that half his cases showed a bad heredity. It will be seen from these references that there is a fairly high incidence of frank psychosis in these cases although an even higher percentage, up to 50%, show a neuropathic or psychopathic pre-disposition in the family history. Although the family history is

apparently worse in the manic-depressive group of cases, this on the whole would be rather what one would expect in any case as the tendency to transmission of mental disorder is higher in the manic-depressive psychoses possibly, than in other types.

In the 25 cases here the family histories show that there were 8 out of the 25 who had had relatives of the same, or previous, generation actually in mental hospital or under treatment for a mental illness. It was impossible in most of the cases to decide from the histories which could be given by relatives, the exact nature of the mental illness from which these relatives suffered, but the fact that they were treated in a mental hospital would seem to indicate that the breakdowns must have been fairly severe. Those eight cases with a positive family history were equally divided between multiparae and primiparae, each group having 4 family histories positive in this way. Over and above these very definite breakdowns a greater number of the patients showed evidence of drunkenness, psychopathy, marked mood variations and other personality disturbances in the family history. Out of the 25 cases there were a total of 11 with such positive family histories, 7 of those 11 being in the group of the multiparae and 4 in the primiparae. In only one case was there a history of both frank psychosis and drunkenness, or minor psychopathy combined in the family history of the patient. That case was primipara Case 2 (I.M.).

In order to assist in the final assessment of the relative importance of different factors in the production of mental breakdown in any one of the 25 cases, the patients with a positive family history, either in the form of frank psychosis or severe mental illness which required treatment, or drunkenness, psychopathy, etc., will be listed.

Case 24, N.C. had a brother who suffered from an obsessional neurosis which was treated by psycho-analysis by Stekel. This brother finally committed suicide shortly after his marriage.

Case No: 17. R.E.W. This patient's mother was an over-anxious worrying personality who had a short depressive illness a year before the patient's own breakdown.

Case Nos. W.S. & M.A. (23 & 13). The mother in these cases had a depressive illness when she was 40 for which she was admitted to mental hospital and where she subsequently died. These two cases were sisters, both of whom had had more than one breakdown in the puerperium and who had also had breakdowns outside the puerperium. Case 23 (W.S) had two puerperal depressive breakdowns and one unrelated to the puerperium. Case 13 (M.A) had had two depressive illnesses in the puerperium, and one for which she was admitted to hospital this time, during the early months of her pregnancy, and two breakdowns outside the puerperium.

Case 22. A.S. The father in this case was rather a psychopathic personality of violent temper who drank heavily and wasted money on gambling. This patient also had one sibling who was supposedly mentally defective and died at the age of six months.

Case 18. R.H. Although there was no frank psychosis in the family history here, neither parent was a particularly stable personality. The mother was over-anxious and rather obsessional herself, with a tendency to periods of depression during which she would consider herself to be in everybody's way and threaten to commit suicide.

Case 25. F.H. The maternal grandfather drank heavily, the maternal grandmother appears to have been rather peculiar, having lived with a man for many years after leaving the maternal grandfather and then suddenly at the age of 70 deciding to marry him. The father

drank heavily and caused frequent violent scenes; and the patient's brother was considered to be nervous although nothing more specific could be ascertained regarding him.

Case 19. V.P. The family history does not appear to play a very significant part in this patient's illness but it is to be noted that the father up till the time of his second marriage, was a heavy drinker, and that the patient's sister, following the birth of her second child, has been very "nervous".

Case 14. M.B. In this case also the family history does not appear to be very significant, the only factor being the father's periodical habit of heavy drinking, and apparent lack of responsibility in relation to his children.

Case 21. A.K. The father in this case appears to have been a psychopathic personality, violent tempered, a heavy drinker, unable to keep a job or accept responsibility for his wife and family. The paternal grandfather also drank heavily but nothing further can be established regarding his personality.

Case 12. M.C. The father of this patient was a publican who drank heavily himself, but other than that there was no family history of either frank psychosis or disturbance of a lesser nature.

Case 8. J.W. The father of this patient was never overtly unstable until in his later fifties he became strange in behaviour, dressing up in women's clothes and flirting with the maids. No further details can be ascertained as to the nature of this disorder.

Case 4. E.H. The maternal aunt of this patient has had periods of "peculiar" behaviour since the age of 20, now being sixty-three. She was never hospitalised but from the description of her behaviour she sounds as though she may well suffer from a periodic catatonic schizophrenic illness. The father in this case was considered to be highly nervous but this dated from shell shock in the first war and prior to that he seems to have been relatively normal.

Case 6. M.H. The father was a nervous man who drank heavily, had marked twitching of the face, a capricious temper and frequent rapid changes of mood. The paternal grandfather drank heavily.

Case 2. I.M. This patient, as already stated, showed both frank psychosis and drunkenness in the family history, the father drank heavily, had a gastric ulcer and was rather erratic in his behaviour. The mother in later life had several breakdowns during which she felt that people were talking about her and shut herself in at home for two months at a time to avoid people.

Case 10. B.E. The brother in this case was treated in hospital for a schizophrenic illness.

Case 11. M.J.C. An aunt was treated in a mental hospital, the nature of her disorder is not known. The paternal cousin has always been considered peculiar, the mother, although not definitely ill, has always been over-emotional, excitable and hypochondriacal.

Case 1. A.V. The father drank heavily and wasted money in gambling.

It is interesting to note that according to Henderson and Gillespie alcoholism is much more common in the parents of the insane than of the sane. They also point out that alcoholism is often a symptom of mental instability in itself. Certainly in these 25 cases of mental illness occurring in the puerperium, there was a high incidence of alcoholism in the parents, particularly the fathers, and in many cases the underlying instability of the personality was also apparent.

The sum total of instability as such, or evidenced by alcoholism in the parents of these cases is shown in Table 5.

Also of interest is Henderson and Gillespie's statement that "Multiple factors have to be postulated, with summation and interaction of juxtaposed genes in the case of manic-depressive insanity, which is now said to depend on a simple dominant, often not manifesting itself except under environmental stress or favourable metabolic conditions".

In these 25 cases depressive reactions were the most common, some certainly of manic-depressive type, so that although one might expect the hereditary tainting to be high, one might also expect that in many of the cases, including those where there was no positive family history, the environmental stresses would be considerable, and in those particularly who had not broken down before, one might postulate the metabolic upheaval of pregnancy and childbirth as the final factor in setting the stage for a mental illness.*

TABLE 4. INCIDENCE OF PSYCHOSIS IN FAMILY HISTORY.

	Psychosis in members of the same or previous generation.	No psychosis in members of same or previous generation.	Approx. incidence of a positive family history.
Multiparae with previous puerperal breakdown	3	7	1/3rd
Multiparae with no previous puerperal breakdown	1	4	1/5th
All cases (Multiparae and Primiparae)	8	17	1/3rd

* The abnormalities in detail in the family history can best be seen in the case histories but the collective results are shown in Tables 4 and 5.

TABLE 5. INCIDENCE OF DRUNKENNESS, PSYCHOPATHY, and.
INSTABILITY IN THE FAMILY HISTORY.

	Drunken- ness, psycho- pathy or instab- ility in the family history	No drunk- eness, psycho- pathy or instab- ility in the family history	Approximate total incidence.
Multiparae with previous puerperal breakdown	5	4	$\frac{1}{2}$
Multiparae without previous puerperal breakdown	2	3	2/5ths
All cases (Multiparae and Primiparae)	11	14	$\frac{1}{2}$

Analysis of Tables 4 and 5.

Although the total number of 25 cases is too small to draw any statistical conclusions regarding the incidence of a positive family history, these tables show that roughly one-third of the total number showed a family history of psychosis, while roughly one-half showed drunkenness, psychopathy or instability in the family history. Further it is to be noted, that in the multiparae with previous puerperal breakdowns, the incidence of psychosis was higher than in those without

previous puerperal breakdowns. This was also the case in relation to drunkenness, psychopathy and instability of the personality.

EARLY ENVIRONMENT.

Although the family history has been studied in great detail in a number of papers on mental illness occurring in relation to childbirth, there have been very few references to the actual relationships within the family group. The importance of these relationships, and especially in their possibilities for the early formation of wrong attitudes, is considerable. In a paper by Chapman in 1947 it is noted that dependency on the mother was frequently observed in cases of puerperal illness with an inability in the patient to assume the role of mother herself. Frequently there was frigidity from fear of pregnancy which had been instilled by the patient's mother.

Jacobs in 1943 also said that there was evidence for the assumption that a neurotic attitude towards marriage was often based on experience in the parental home.

Lloyd Thompson, in 1942, pointed out that women with good relationships, and with ability to identify themselves with their mothers, have a resilience and capacity to cope with pregnancy and childbirth. He also stated that good relationships between the patient's parents was also an important

factor.

Saunders, in 1928, also suggested that the early environment and childhood experiences, particularly those affecting the ability for adjustment to normal sex life in later years, were important. She more specifically mentioned, as possible adverse factors, abnormality in the father in the form of excessive tenderness, or mother attachment with hatred of the father which she suggested led to a tendency towards homosexual attachments. In addition she mentioned domestic friction, resulting in fixation on the remaining parent with guilt feelings regarding differences between them, and resistance, in the light of this, to marital relations in later life on the part of the patient. The cases which she recorded showed content which was referable to early life experiences. She, too, noted that the attitude of the mother, if at all abnormal, might lead the patient to repudiate motherhood in later life. It was thought that owing to the suggestion made in these papers of the importance of abnormalities in the early life of these patients, that it would be of interest to study parental relationships in more detail. Actual maladjustments of the parental marriage, or other abnormal parent situations such as unsatisfactory step-parents, etc., were taken into consideration. Further, in assessing the importance of these poorly adjusted early backgrounds, it was thought that actual neurotic symptoms present in childhood in the 25 cases

studied here, would act as a further confirmation of the degree of maladjustment in the early home life. Some attempt has therefore been made to study these two factors in relation to one another, and the table shown at the end of this section will provide actual figures regarding both unsatisfactory early backgrounds and the presence of neurotic symptoms in childhood in the patients.

In these 25 cases, nineteen of them showed fairly marked maladjustments of the parental marriage or some other abnormality in the parental situation, such as step-parents. Of these 19, eleven occurred in the multiparae and eight in the primiparae. In comparing these with the number of cases who showed neurotic symptoms in childhood, one sees that there were 19 of the cases who showed such symptoms, eleven of them were multiparae and the other eight primiparae.

Each individual case will now be studied:-

Case 24. N.C. There were violent quarrels in the patient's early home life between the parents and following the mother's death the father remarried. Although the patient was twenty at this time she became extremely ill and attempted to poison herself. During childhood this patient was enuretic so that there was evidence that the disturbed parental situation did have its repercussions on the patient.

Case 17. R.E.W. Although in this instance the parental situation seems to have been fairly normal, the patient did show the neurotic symptom of sleep-walking in childhood. It would appear that this disturbance may well have been related to the fact that her parents were never very sympathetic in their attitude towards her, and the father particularly had hoped that she would be a boy and in his disappointment favoured the other sisters in preference to the patient.

Case Nos. W.S. & M.A. (23 & 13). Here again there was no evidence of maladjustment of the parental marriage but the total family situation was abnormal in the respect that the mother died when the patient W.S. was aged three and the patient M.A. was aged ten. Subsequently the father re-married and there were violent quarrels between the stepmother and the father. The patient M.A. was sent away to the grandmother after the father's remarriage and it was of interest to note that she showed no neurotic symptoms whereas the patient W.S. remained at home, became enuretic and remained so until she was ten. The financial difficulties in their early childhood days must also have tended to increase the insecurity of these two patients.

Case 22. A.S. In this instance the drunken and violent behaviour of the father, and the fear which he instilled into both mother and children in the family must have caused the patient a considerable amount of anxiety in her childhood. In addition the poverty in the home because of the father's habits led to increased insecurity. Evidence of this is to be seen in the fact that the patient was considered a "nervous child", spoke with a lisp until she was ten, and was afraid of school teachers and of the dark.

Case 18. R.H. The family situation here was considerably disturbed, with constant violent quarrels between the parents in which there was frequent physical violence. There was a tendency on the part of the father to make rather a fuss of the patient, in such a way as to play her off against her mother, which the patient noted and found very disturbing, particularly during her adolescence. There was no incentive to the patient to interest herself in domestic affairs as both her mother and sister considered her inadequate at this and preferred to do it themselves. - This in later life leading to the patient assuming almost automatically that she would be unable to do such things. The re-marriage of the father and the arrival of a younger group of step-siblings, which the patient at one time looked after, caused her much jealousy and further insecurity.

Case 25. F.H. In this case the paternal strictness and heavy drinking with consequent fear on the part of the patient for him; and witnessing parental intercourse at an early age, during which she identified herself with her mother with hatred of her father; may have influenced her attitude towards marriage and childbirth in later life. There was also marked over-attachment to the mother with later inability to wean herself from her and form an adult relationship with her husband. In spite of the disturbance in the home the parents got on reasonably well together. The patient showed no actual neurotic symptoms

in childhood but her adjustment to sexual matters was poor. She was always upset during her periods, resented having them and considered men to be much more fortunate. This attitude persisted into later life.

Case 16. E.L. Although the parental marriage was not grossly maladjusted in this case, the domineering, rather neurotic mother, probably had a considerable effect on the patient. The mother's early sexual misdemeanours resulted in two things, firstly the instilling of abnormally strict warnings in relation to men and secondly considerable resentment towards the mother for having had an illegitimate child. The question of possible venereal infection in the mother also influenced the patient who has felt since, that there was a possibility that she might transmit the disease to her children. The last important factor in this patient's early background was the considerable attachment she had to the maternal grandmother and the attitude towards religion which was instilled by the grandmother. It is to be noted that the patient from an early age considered that she herself would never marry and held the view, which one must presume was introduced by the mother, that men "were devils, always demanding intercourse, stinting their wives of money or ill-treating them". This patient showed neurotic symptoms which may have been related to rejection by the mother, although there is no definite proof of this except that the mother had excessive vomiting in pregnancy when she was carrying the patient, and the patient was the only one of her children not breast fed. In addition to this there was considerable sibling rivalry with her elder sister who had a weak heart and was much fussed over.

Case 19. V.P. The death of this patient's mother when she was seven and the subsequent remarriage of the father to a stepmother with whom the patient could not get on, seem to have been potent factors in building up early feelings of insecurity in the patient. During childhood she showed sleep walking. In later life she was forced by the stepmother into domestic work against her wishes which she disliked intensely. Although the father and the stepmother appear to have got on quite well, the patient never seems to have felt included in the family group, but ever since the father's remarriage, rather compelled to stand on her own feet.

Case 14. M.B. This patient's early background was extremely abnormal, the mother died when she was five and the father remarried when she was fourteen. Although her relationship with her father had been a close one until then the home was subsequently made very unhappy by the stepmother who was constantly causing quarrels. When the patient was only sixteen the parents left her in the care of a neighbour, the atmosphere of whose home was as unhappy as her own had been, with constant quarrelling. During childhood the patient showed the one neurotic symptom of sucking her fingers.

Case 21. A.K. The early background in this case was again abnormal, the father's instability and the poor relationship between the parents with constant violent quarrelling, and the ultimate departure from the home of the mother when the patient was only fourteen, must have undoubtedly had their repercussions on the patient. This was particularly so as the patient was left to move from place to place with the father whom she feared because of his violent temper. She was extremely fussy about her food in childhood and during adolescence extremely nervous, afraid to go out in the dark and terrified of a man looking at her in the street.

Case 20. M.L. Although not sufficient is known of the early background in this case to form any accurate opinion, owing to the age of the patient at the time of admission, it does appear that the mother's death when the patient was only seven, and the father's ultimate remarriage, may have played a part in the patient's subsequent breakdown. The stepmother took to drink and the home was broken up. The treatment of the patient by the stepmother was very bad, and very restrictive, and she was forced by the stepmother into domestic work which she did not like. She showed nail biting in her early years which persisted into adult life. Her attitude to menstruation was abnormal in that she was extremely resentful about it and would have preferred to be a man.

Case 12. M.C. The early quarrels between the patient's parents and later between the mother and stepfather following the father's death and the remarriage of the mother, appear to have caused a lot of unhappiness and insecurity in the patient's early days. The domineering personality of the mother too seems to have had its repercussions in the patient who in adult life seemed able to carry on reasonably efficiently under her mother's direction, but was unable to become completely

independent and stand on her own feet. During childhood there was evidence of this insecurity in the fact that the patient was always a nervous child, showed sleep walking and talking, and was afraid of people in authority.

Case 8. J.W. The parental quarrels in the patient's early life caused some degree of insecurity in her. Her identification with her father and his insistence on the importance of intellectual achievements persisted into adult life and seem to have affected her relationship to her husband who also stressed the importance of intellectual pursuits. There was never a satisfactory identification with the mother whom the patient considered inadequate and intellectually her inferior. In spite of parental quarrels in this case the patient showed no neurotic symptoms in childhood.

Case 4. E.H. There was constant friction between the patient's parents, in this case, and the mother's nagging, over-fussy attitude towards her in early childhood seems to have led to an inability in the patient to ever emancipate herself entirely. In her early days she showed difficulty with food and bit her nails. In this case the attitude to childbirth itself was apparently greatly influenced by that of the mother. The constant reiteration that childbirth "messed up one's inside", and her advice to the patient never to have children, certainly carried on into the patient's adult life. It showed itself, firstly, in her determination never to have a child, and secondly, at the time when she did in fact give birth, in the development during her illness of marked hypochondriacal ideas, particularly associated with damage done to her inside.

Case 3. R.W. Although there was no disturbance in the parental marriage in this case there was a strong identification of the patient with her father, particularly in her belief in the value of intellectual pursuits which persisted into adult life and resulted in the attitude that childbirth would interfere with her intellectual activities. The age of the mother at the time of the patient's birth, its association with feelings of shame, and the over-restrictive attitude of the mother towards the patient in her childhood, were effective in influencing the patient's later development and personality structure. There was no satisfactory identification with the mother. The restrictiveness of the patient's early background is further evidenced by her frequent temper tantrums when thwarted.

Case 5. J.S. The fact that this patient was herself an illegitimate child makes it extremely difficult to assess the relative importance of various factors in her early life. Of the traits she inherited, nothing is known, as there is no information regarding the real parents. Although the adoptive parents were stable enough people and their marriage reasonably adjusted, the patient's discovery at the age of fourteen that she was an illegitimate child seems likely to have created feelings of insecurity in her. In spite of the fact that she did not know about her illegitimate birth until she was fourteen, in earlier childhood there was evidence of insecurity in the form of various neurotic symptoms.

Case 6. M.H. The parental marriage was grossly maladjusted in this case. The patient seems to have identified herself chiefly with her father who was extremely temperament and had numerous nervous habits. Any attempt at the formation of a relationship with her mother was unsatisfactory in view of the mother's cold, self-sufficient personality and her preference for the patient's brother. The fact that the mother discouraged the patient from helping in the domestic sphere at home may well have played a part in her inability during her own married life to manage her household affairs. Evidence of her disturbed childhood is shown in the numerous neurotic symptoms which she exhibited at that time. She had violent temper tantrums when thwarted which continued into adult life, and her attitude to menstruation was abnormal. Her subsequent frigidity in marriage may have been in part attributable to the complete taboo on discussion of any matters pertaining to sex life, in her early home life.

Case 9. M.D.H. There is little that is grossly abnormal in this patient's early background. The only possible disturbing factor may have been the death of the patient's mother when she was fourteen. The stepsister who assumed the mother's role did so altogether inadequately so that the patient was often poorly fed and not happy.

Case 2. I.M. The parental marriage was grossly maladjusted in this case with frequent violence between the parents which was witnessed by the patient. On several occasions the mother and she ran away from home altogether to escape the father's tyranny, but were always forced to return. As a result of this, as a child she was sensitive and very shy, cried easily and was over-anxious to please people. These features persisted into later life and seem to have fostered a lack of confidence in her own ability and made her unable to accept responsibility. This latter factor seems to have played a part in her inability to cope with the responsibility of a child.

Case 10. B.E. The parental marriage does not appear to have been disturbed in this case, but in spite of this the patient showed fears of the dark and of being left alone which started in childhood and persisted into adult life.

Case 11. M.J.C. The parental marriage in this case was maladjusted with frequent major disagreements between the parents. There was a close relationship between the patient and her father, with consequent disappointment in him when he was unable to stand up to the mother's constant criticism and nagging. The mother was over-restrictive towards the patient during her childhood and as a result of this she showed numerous neurotic symptoms, some of which persisted late into adolescence. The mother's habit of nagging and dictating to the patient seems possibly to have caused a delay in her attaining maturity and accepting responsibility. During adolescence the patient was evacuated from home between the ages of ten and fourteen and led a very unsatisfactory and unhappy life, which may have been responsible for her showing at that time, a number of features of emotional disturbance in the form of stealing small sums of money, wild and destructive behaviour, and early sexual experience.

Case 7. S.R. There was no disturbance in the family background in this case. The patient, however, was a nail-biter which apparently had also been a habit of her mother's.

Case 1. A.V. The instability and drunkenness of this patient's father seem to have caused her considerable fear in childhood. There was frequent violence between the parents as a result of which the patient was highly strung as a child and walked in her sleep.

In order to sum up the detailed description of the early environment of the 25 cases, the following table is given, and shows abnormalities in the parental situation and neurotic symptoms exhibited by the patient in childhood.

TABLE 6.

	Patients with neurotic symptoms in childhood.	Patients with- out neurotic symptoms in child- hood.
Maladjustment of the parental situation	15	4
No maladjustment of the parental marriage or ab- normal parental situation.	4	2

This table shows that in the 25 cases studied here maladjustment of the parental marriage or other abnormal parental situations were present in a high proportion of the cases. The importance of the parental disturbances is further emphasized by the high incidence of neurotic symptoms occurring in these patients during childhood.

P E R S O N A L I T Y.

Henderson and Gillespie define personality as used in clinical psychiatry as "the integrated activity of all the reaction-tendencies of the daily life of the individual". They also say that the term is commonly used in a wider sense regarding it 'as the total integrated expression of various "levels" of which the individual is constructed.' Using it in the latter sense they point out that certain personalities are less adapted to adjust to environmental circumstances than others, and that 'this may be the result of inherited handicap or of faulty training and habits'.

In the previous sections of this thesis the inherited handicap and the early environment have been studied, so that this section is left to deal mainly with an assessment of the resultant of these forces in the form of the adult personality structure. Even with the aid of relatives and friends as informants any such assessment is bound to be a subjective one and therefore not very reliable. No set formula has been used in assessing the personalities of these 25 cases, but rather the features which seemed to be common to the largest number have been extracted and tabulated.

In the literature, which has appeared during the last twenty to thirty years, there have been several references to the part played by the personality of the individual in the production of mental illness in relation to childbirth. In 1926 Kilpatrick and Tiebout described the previous personalities of their

non-toxic delirial group as being 'unstable with constitutional weakness' but felt that the toxic delirial group showed less constitutional predisposition.

In dealing with his post-partum schizophrenic cases, Zilboorg in his paper, discussed the psychopathological mechanisms which play a part in the promotion of breakdowns at this time. He suggested that "social demands make many of these women aspire to marriage and motherhood when in fact these demands are not infrequently in direct conflict with those fundamental biopsychological tendencies" which, as he puts it, "express the synthesis, as it were, of her libido development". He stated that there was an identification with the parent of the opposite sex and that they "need no man and wish no feminine role in life". He also stated that many develop homosexual attachments after the outbreak of their psychosis. He also stated that they are unusually well during pregnancy and that there is an unconscious equation of the child with the penis and that it is the loss of the child, i.e., the penis, which produces the breakdown, this being so, because the women's pattern of life is being a man. The delivery itself is, as it were, reinforcing early castration fears. He stated that their reaction type is an anal possessive retentive one, thus childbirth is extremely traumatic to them. With this anal narcissism there is an inability to identify with the mother, or in fact an inability to be a woman. Their attitude therefore to the child when it is born is one of indifference.



In the depressive cases which he studied during the post-partum period, he noted an unresolved mother-child identification and said that the death instinct set free during parturition engulfs both mother and child, so that infanticide and suicide in post-partum depressions are common, with the early sense of guilt reinforced by the birth of the child. The post-partum depressions, he stated, have not the same drive to masculinity as do the post-partum schizophrenias and he thought that they appeared to be caught midway between complete acceptance of their femininity and complete masculine assertion with resultant homosexual tendencies. For this reason, according to Zilboorg, they are only partially or transiently frigid. They are strongly ambivalent in their attitude towards their marital partner, their children, and therefore towards themselves. The prime movers in depressive reactions as a result of childbirth, he thought, are incest and hostility. At times the hostility may be mainly against the husband, and the unconscious hostility against the child less. This happens usually when masculine identification is more complete. If this identification is too complete it leads to total frigidity, that is, the refusal to play a feminine role. In this case he thought there was a tendency to retain the infantile impression of married life as a hostile relationship, the father being the aggressor. As a result of this there is therefore partial identification with the mother and a mixture of hostility and passivity, pseudo-masochistic in

in nature, leading to psychological confusion with fear of "natural birth". In many cases the father is responsible for a too masochistic image of motherhood and there is therefore hostility to him, and later to the husband who is identified with him, leading to death wishes towards the husband. He thinks that these maladjustments become clear not infrequently only after a mental illness has developed. Because of this he feels "that purely psychiatric prevention of such illnesses is hardly ever, or very seldom possible", but considers,"that this remains a problem for the future, when preventive psychiatry will have gained a higher level of scientific systematisation and a more extensive body of facts with regard to the psycho-dynamics of human development".

When Zilboorg wrote that in 1929, it seemed that he was not optimistic regarding the possibilities of prevention of mental illness related to childbirth. It is hoped that in studying the personalities of these 25 cases that, although the whole psychopathology may not have been clear cut prior to delivery, that in fact there were certain features which might have been noted and acted as signposts to the possibility of post-partum mental illness.

Zilboorg, in 1928, noted "aloofness, shyness in the presence of men, prolonged courtship, and persistent frigidity in marriage" as features of the personalities of his group of cases of schizophrenic illness occurring in the puerperium. The same author in a paper written

in 1930 on depressive reactions to parenthood, quoted Abraham as saying that "individuals suffering from manic-depressive psychosis, especially depressive type, show in their free intervals almost the same psychological reactions and instinctual characteristics as compulsive neurotic personalities and that they differ from the latter only in one respect, they are less, if at all, capable of a real object libidinous attitude towards life".

Since the time of Zilboorg's writing there have been a number of papers which have gone into the question of the personality of these patients in more detail.

In the same year Strecker and Ebaugh felt that "the kind of mind with which the patient approached labour," was one of the important factors in the production of breakdowns at this time.

In 1933 Anderson studied 50 cases of puerperal mental illness in relation to the sex life of the individuals concerned, and noted that the pre-psychotic sex life was in no way different from that in cases of non-puerperal mental illness. Nor did he note persistent frigidity as being distinctive in these patients. In 1939 Hayworth, in a study of 117 cases showed that in 29 of these cases there was "nervous instability" in the pre-psychotic personality but no criteria are laid down as to what was meant by the term "nervous instability".

In 1940 John Smallldon noted in his series of cases that those who showed a toxic-infective reaction (which was a small number) failed to show the comparatively large number of personality deviations which Strecker and Ebaugh had previously noted. This they considered threw doubt on the validity of infection and exhaustion as being the sole specific aetiological agents. He did not confirm Zilboorg's theory of a high percentage of incest ideas and homosexuality in the depressive reactions, nor his claim of an unresolved Oedipus situation in most of the puerperal schizophrenias. It was suggested that a slightly greater number of his patients showed a mother, rather than a father preference and on the whole the study of his group of cases would tend to refute rather than confirm many of Zilboorg's findings. He did not think that persistent frigidity pointed to the impending development of a schizophrenic reaction in the puerperium. Broadly speaking, Smallldon felt that psycho-endocrinological explanations of certain cases were correct and accurate, but thought it possible to postulate from these cases that other similar cases developed from a similar set of circumstances and by means of the same dynamics. Also in 1940 Cruickshank noted a high incidence of pre-psychotic instability in his 84 cases, and that evidence of gross personality defect was higher in manic-depressive and schizophrenic groups than in the toxic-exhaustive.

In 1941 Kraines noted that there were serious difficulties, (not specified), in the previous personality of women who developed puerperal mental illness. In 1942 Ordway and MacIntyre in their study of 45 cases, noted that 18 out of the total number of patients were unstable before marriage. Also in 1942, a paper on pregnancy psychoses by Hinson stated that these women were "queer", anti-social and emotionally unstable. In 1943 Cohen said that the previous personalities of these women showed a hypochondriacal make-up, especially in relation to their attitude to their own bodies, and that this attitude might be carried on to the time of labour and influence their attitude towards the pain of labour. He felt that the personality of the patient was important in the development of certain attitudes as to whether she will regard pregnancy as an encroachment of the world upon her or will regard it as an extension of her own already extended ego. He felt that an over-dependent attitude of a hypochondriacal one will lead even in a normal pregnancy to a prolonged period of recovery in the puerperium. In some cases he felt that the personality might be such as to make the woman literally unable to take an interest in the baby.

In a more recent work still, Chapman, in 1947, noted that there is an antagonism to the opposite sex, a dependency on the mother with an inability to assume the role of mother herself and frigidity from fear of pregnancy instilled by the mother,

frequently present in these cases.

In the study of these 25 cases various aspects of the personality that have been mentioned by other authors have been taken into consideration, as well as additional factors which seem to be of importance because of a fairly frequent recurrence in several of the cases studied. The attitudes to menstruation, or to sexual matters, and neurotic symptoms in childhood, were noted in conjunction with relationships in the early home background. The main aspects of the previous personality that were studied in these 25 cases were as follows:-

- (1) The patient's work record.
- (2) Exceptionally high standards or obsessional traits.
- (3) Over-dependence on either parent.
- (4)and (5) Hypochondriasis, and Mood variations.
- (6) Over-anxiety.
- (7) Ambitious - socially or otherwise.
- (8) Desire to be a boy or have only male children persisting into adulthood.
- (9) Inability to mix with people, or few friends.
- (10) Insecurity.
- (11) Conscious rejection of motherhood.

Frigidity, or other maladjustments in the marital situation which were due to sexual or other causes will be considered under the section "Life Situations" sub-heading "Marriage". Each case will now be studied individually under these headings.

Case 24. N.C. This patient was always over-emotional, given to mood swings and was over-ambitious.

Case 17. R.E.W. This patient was a quiet, reserved, sensitive personality. She had few friends and was a poor mixer. She was always over-inclined to worry about hurting other people's feelings and was basically over-anxious and insecure.

Case 23. W.S. This patient never had any friends or social contacts and was unable to mix with people. She was subject to mood swings, more particularly since the birth of her first child. She was over-attached to her mother. Socially she was ambitious for herself and her husband but felt ill-at-ease with people of better social class than herself. She had particularly high standards of cleanliness, especially in relation to her house which was her main interest, and would work late into the night to keep things in order. Her work record was unstable.

Case 18. R.H. This patient was subject to mood swings with periods of depression. She was always a worrying, anxious, insecure personality, hypersensitive to adverse criticism and over-attached to her father. She set herself high standards which she was unable to maintain, particularly in relation to her house, with resultant anxiety when she was unable to maintain these. She worried excessively about her own health. She wanted from earliest days to be a boy and this persisted into adulthood and later expressed itself in her unreasonable determination to have male children.

Case 25. F.H. The work record in this case was extremely unstable and inadequate. She was considerably over-attached to, and dependent on, her mother. She was to a certain extent hypochondriacal, easily tired and set herself excessively low standards because of her hypochondriacal attitude towards herself. This case too showed a desire, which persisted into adulthood, to be a man rather than a woman, although she did not have any desire to have a male child. There was, however, a conscious rejection of motherhood altogether. She was over-anxious and insecure.

Case 16. E.L. The work record was not very satisfactory. She had a number of jobs and her reasons for leaving were frequently very inadequate ones. She was over-attached to her mother and had a tendency all her life to be hypochondriacal. She was over-anxious, worried about trifles and was extremely houseproud and fussy about neatness both in her home and her personal appearance. Her moral standards were particularly strict.

Case 19. V.P. The work record in this case was extremely unsatisfactory, partly due, of course, to the fact that she was forced by her stepmother into work which she did not like. She was subject to mood swings and became easily depressed about minor matters. She had too extremely high standards of cleanliness and neatness in her home and would become grossly over-anxious if these

could not be maintained. Her early background led to a great deal of insecurity, and socially she was extremely ambitious for herself and her husband.

Case 15. E.D. This patient's personality would appear to have been fairly stable on the whole except that there was a degree of over-attachment to the mother, high standards in her house and personal appearance, and over-anxiety if these could not be maintained. She was extremely thrifty with money.

Case 14. M.B. This patient was subject to mood swings. She worked excessively hard over her house and children, insisting on neatness and cleanliness to an extreme degree and nagging if things were not just so. She had been over-attached to her father in childhood and in her later life was over-dependent on her husband. She was an anxious, insecure personality, sensitive, self-conscious, with a tendency to run herself down because of her poor educational level.

Case 21. A.K. This patient showed an unstable record with regard to work with inability to stick to any one job and frequent changes for inadequate reasons. She was a poor mixer, rather highly strung and over-anxious, always over-dependent on her mother and this dependence became more marked following marriage and childbirth. She was excessively fussy about her house and her personal appearance and meticulous in money matters.

Case 13. M.A. This patient was subject to mood swings, had few friends and did not mix easily.

Case 20. M.L. This patient showed rather a rigid personality with excessively high standards. She was over-methodical in her house and her obstinacy and independence were striking. From her earliest days she would have preferred to have been a man and was abnormally determined to have only male children in spite of being a militant feminist herself.

Case 12. M.C. This patient's work record was very inadequate. She was fired from her first job as a secretary and later during her work in her mother's pub she was entirely over-dependent on the mother in everything she did. She too was extremely fussy about her house and personal appearance, and although she allowed things to become chaotic at times she would have frequent bouts of tidying things away. She was socially ambitious and is quoted as having had "the greatest possible aversion to going down the social scale". She showed a conscious rejection of motherhood, never wanted to have any children, and procured frequent miscarriages to obtain these ends. Much of this was possibly related to her own considerable degree of insecurity.

Case 8. J.W. This patient was always excessively sensitive and shy, particularly on meeting new people although in spite of this she had numerous superficial friends. She was extremely snobbish as was her mother before her. In many ways she was rather a rigid personality, unable to make adjustments and took excessive pride in her housekeeping. She had a slight tendency to hypochondriasis, particularly after the death of her mother from cancer, thinking that she too might develop this disease. She was closely identified with her father, whose interests in later life she took as her own and transferred a degree of her dependence on to her husband.

Case 4. E.H. This case showed over-dependence on the mother although there appears to have been a constant struggle away from her. As already noted, her attitudes to childbirth were much influenced by the mother, with a resultant rejection of motherhood. Although she had many friends she was over-concerned with other people's opinion of her, over-anxious about trifles, and socially very ambitious and anxious to conform to convention. All this would seem to indicate some degree of insecurity and over-anxiety in her own personality. Her standards regarding her house and person were extremely high and she would become fidgety if things were not exactly right, although normally when she was well she was a very capable manager. She was particularly careful in money matters and had the habit to an abnormal degree, of making lists of everything that she did.

Case 3. R.W. This patient showed a strong identification with her father whose attitude regarding the importance of intellectual pursuits she maintained into adult life. This apparently caused her a great deal of trouble ultimately in adjusting to a domestic and childbearing role. She was constantly searching for new intellectual conquests. She was an obsessional personality and although not particular about tidiness, etc., prior to marriage, became markedly over-particular regarding dust and cleanliness following her marriage and could never be persuaded to relax her standards. She was always over-anxious about new work but became easily bored once she had mastered it. In this case there was a very definite conscious rejection of motherhood which was in direct conflict with her intellectual aspirations.

Case 5. J.S. This patient was an insecure adopted child who showed her insecurity in many small ways. Her work record was extremely unsatisfactory. She was inclined to mood swings and normally was a domineering, superficial personality who had constantly to be in the limelight. In minor ways she was rather over-particular about her personal appearance. She showed preference for being a man rather than a woman, was more interested in men's pursuits and took a keen interest in football.

Case 6. M.H. This patient had an unstable work record, was totally unambitious and was given to violent swings of mood, especially when she was thwarted. This latter feature of her personality dated from her early childhood. She was over-attached to her father, especially in her younger days. Although at times there seems to have been an attempt to identify with her mother, the cold, unsympathetic personality of the mother, with her preference for her male children, made such an identification difficult if not impossible for the patient. She was always mildly hypochondriacal and worried about T.B. and cancer. She was extremely egocentric. The standards which she maintained in her home and personal appearance were excessively high in spite of her distaste for domestic activities which seems to have been engendered by her mother during her early days at home. There was a conscious rejection of motherhood in this case. She disliked the distortion of her own body during pregnancy and seemed to regard childbirth as an encroachment of the world upon herself. She was over-anxious and insecure.

Case 9. M.D.H. In this patient there was always a tendency to self-consciousness and she was sensitive and undemonstrative with few close friends. She was rather closely attached to her own mother, greatly upset by her death and during her years of adolescence it seems that there was no real substitute for her own mother. Although she was houseproud and kept her home "like a new pin" she was not abnormally fussy.

Case 2. I.M. This patient was grossly insecure and over-anxious. She worried about other people's opinion of her and was unable to accept responsibility. Although her work record from the point of view of frequent changes was not poor, she was unable to accept responsibility when she was offered promotion. She was a poor mixer because of her excessive concern regarding what others thought of her and all her life had been over-attached to her mother.

Case 10. B.E. The mother in this case was an extremely domineering woman whose domination the patient seems to have accepted and a close relationship existed between them. The patient had always been very sensitive and found it difficult to mix with other people. This latter feature of her personality may, in part, have been due to her poor eyesight and her deafness. She was extremely fussy about her house and personal appearance and became anxious if these standards were not maintained.

Case 11. M.J.C. From earliest childhood this patient showed considerable mood swings which persisted into adult life. She was always over-neat and tidy and considered to be too fussy for a young girl. Following her marriage she would get much upset by dirt or disorder in her home and found difficulty in completing her housework within reasonable hours because of her high standards. She was always reserved and shy, disliked meeting new people and found it difficult to mix with others. She had a close attachment to her father and following her marriage was over-dependent on her husband. She preferred the company of men and would herself have liked to have been a boy.

Case 7. S.R. On the whole this patient seems to have been a reasonably stable personality, the only features of interest being her extreme sensitiveness and over-zealous avoidance of quarrels. She was probably rather reserved and unable to express her troubles.

Case 1. A.V. This patient showed an unstable work record. As a child she was highly strung and coming from a family of rather lazy, shiftless people, she herself disliked hard work, and in her adult life particularly, the domestic chores of a housewife.

The following table sums up the various personality features which have just been discussed in each individual case. In addition, the total number of cases showing various personality traits has been worked out in percentages, and will be shown in the tables following this one. The figures cannot be considered to have any statistical significance as the total number of cases was too small. They serve only to indicate certain trends in the personalities of these 25 patients.

TABLE 7 (a)

M U L T I P A R A E

	WORK RECORD	UNSTABLE OR INADEQUATE	MOOD SWINGS	POOR MIXER OR FEW FRIENDS	OVER DEPENDENCE ON PARENTS (MOTHER - M) (FATHER - F)	OBSSESSIONAL TRAITS-HOUSE PROUD-HIGH STANDARDS ETC.	SOCIALLY OR OTHERWISE AMBITIOUS	HYPOCRISY OR EASILY TIRED	DESIRE TO BE A BOY OR HAVE MALE CHILDREN PERSISTING INTO ADULT LIFE	OVER-ANXIOUS	INSECURE	CONSCIOUS REJECTION OF MOTHERHOOD
N.C.	X	-	-	-	M	X	X	X	-	-	-	X
R.E.W.	-	-	-	X	-	-	-	-	-	-	X	-
W.S.	-	-	X	X	-	-	-	-	-	X	-	-
A.S.	X	-	X	X	M	X	-	X	-	-	-	-
R.H.	-	-	X	-	F	X	-	X	-	X	-	-
F.H.	X	-	-	-	M	-	-	X	-	X	-	-
E.L.	X	-	-	-	M	X	-	X	-	X	-	-
V.P.	X	-	X	-	-	X	-	-	-	X	-	-
E.D.	-	-	-	-	M	X	-	-	-	X	-	-
M.B.	-	-	X	-	F	X	-	-	-	X	-	-
A.K.	X	-	-	X	M	X	-	-	-	X	-	-
M.A.	-	-	X	-	-	X	-	-	-	-	-	-
M.I.	-	-	-	-	-	X	-	-	-	-	-	-
M.C.	X	-	-	-	M	X	-	X	-	-	-	-

TABLE 7 (b)

P R I M I P A R A E

[illegible]

TABLE 8.

WORK RECORD. Unstable or Inadequate.
(All cases - 36%)

<u>MULTIPARAE.</u> (22) A.S.	<u>PRIMIPARAE</u> (6) M.H.
(25) F.H.	(1) A.V.
(16) E.L.	(5) J.S.
(19) V.P.	
(21) A.K.	
(12) M.C.	
TOTAL - 6. (42.8%)	TOTAL - 3. (27.2%)

HOUSEPROUD. High Standards or Obsessional Traits
(All cases 64%)

<u>MULTIPARAE.</u> (22) A.S.	<u>PRIMIPARAE</u> (4) E.H.
(12) M.C.	(3) R.W.
(15) E.D.	(5) J.S.
(18) R.H.	(6) M.H.
(14) M.B.	(9) M.D.H.
(20) M.L.	(10) B.E.
(16) E.L.	(11) M.J.C.
(21) A.K.	
(19) V.P.	
TOTAL - 9. (64.2%)	TOTAL - 7. (63.6%)

OVER-ANXIOUS. (All cases 56%)

<u>MULTIPARAE.</u> (15) E.D.	<u>PRIMIPARAE</u> (4) E.H.
(17) R.E.W.	(3) R.W.
(19) V.P.	(6) M.H.
(18) R.H.	(2) I.M.
(14) M.B.	(10) B.E.
(23) W.S.	
(21) A.K.	
(25) F.H.	
(16) E.L.	
TOTAL - 9. (64.2%)	TOTAL - 5. (45.4%)

OVER-DEPENDENCE ON PARENTS. (All cases 64% -
Total - 40% Mother)
24% Father)

<u>MULTIPARAE</u> M. (22) A.S.	<u>PRIMIPARAE</u> F. (8) J.W.
" (12) M.C.	M. (4) E.H.
" (15) E.D.	F. (3) R.W.
F. (18) R.H.	F. (6) M.H.
" (14) M.B.	M. (9) M.D.H.
M. (21) A.K.	M. (2) I.M.
" (25) F.H.	M. (10) B.E.
" (16) E.L.	F. (11) M.J.C.
TOTAL = 8. (57.1%)	TOTAL - 8. (62.7%)
6M. (42.8%)	4M. (36.3%)
2F. (14.2%)	4F. (36.3%)

MOOD SWINGS (All Cases - 40%)

<u>MULTIPARAE</u>	(22) A.S.	<u>PRIMIPARAE</u>	(5) J.S.
	(24) N.C.		(6) M.H.
	(19) V.P.		(11) M.J.C.
	(18) R.H.		
	(14) M.B.		
	(13) M.A.		
	(23) W.S.		
<u>TOTAL</u>	<u>7. (50%)</u>	<u>TOTAL</u>	<u>3. (27.1%)</u>

SOCIALLY AMBITIOUS. (All cases - 28%)

<u>MULTIPARAE</u>	(22) A.S.	<u>PRIMIPARAE</u>	(8) J.W.
	(12) M.C.		(4) E.H.
	(24) N.C.		(3) R.W.
	(19) V.P.		
<u>TOTAL</u>	<u>4. (28.5%)</u>	<u>TOTAL</u>	<u>3. (27.1%)</u>

POOR MIXER OR FEW FRIENDS. (All cases - 36%)

<u>MULTIPARAE</u>	(22) A.S.	<u>PRIMIPARAE</u>	(8) J.W.
	(17) R.E.W.		(2) I.M.
	(13) M.A.		(10) B.E.
	(23) W.S.		(11) M.J.C.
	(21) A.K.		
<u>TOTAL</u>	<u>5. (35.7%)</u>	<u>TOTAL</u>	<u>4. (36.3%)</u>

WANTED TO BE A BOY OR HAVE MALE CHILDREN. (all cases 20%)

<u>MULTIPARAE</u>	(18) R.H.	<u>PRIMIPARAE</u>	(5) J.S.
	(20) M.L.		(11) M.J.C.
	(25) F.H.		
<u>TOTAL</u>	<u>3. (21.4%)</u>	<u>TOTAL</u>	<u>2. (18.1%)</u>

HYPOCHONDRIACAL OR EASILY TIRED. (All cases 24%)

<u>MULTIPARAE</u>	(18) R.H.	<u>PRIMIPARAE</u>	(8) J.W.
	(16) E.L.		(6) M.H.
	(12) M.C.		
	(25) F.H.		
<u>TOTAL</u>	<u>4. (28.5%)</u>	<u>TOTAL</u>	<u>2. (18.1%)</u>

INSECURE. (All cases - 48%)

<u>MULTIPARAE</u>	(12) M.C.	<u>PRIMI PARAE</u>	(4) E.H.
	(17) R.E.W.		(5) J.S.
	(19) V.P.		(6) M.H.
	(18) R.H.		(2) I.M.
	(14) M.B.		(11) M.J.C.
	(25) F.H.		(1) A.V.
 TOTAL	 <u>6. (42.8%)</u>	 TOTAL	 <u>6. (54.5%)</u>

PRECIPITATING FACTORS AND ADVERSE LIFE SITUATIONS.

Henderson and Gillespie have stated that important mental factors in the aetiology of mental illness "may be divided into two classes, social and intrinsic", the latter being more subtle and acting as "mental precipitates of environmental influences". The commonest social factors they quote as being financial or business worries, domestic difficulties, dissatisfactions of all kinds, disappointments and worries in the sexual sphere, and deaths of relatives. They pointed out that an individual "may surmount one difficulty successfully only to go down before an accumulation of troubles". It is, they feel, not the situation itself but what the subject feels about it that matters.

In considering the social factors Henderson and Gillespie feel that the most universally operative of these is emotional insecurity in early life, which can arise "especially from unsatisfactory relationships between parents and child which again is naturally influenced by unsatisfactory relationships between the parents themselves". They say "in early life this may produce a nervous child and the effects can persist into adult life to produce the nervous adult prone to psychoneurotic reactions, or, especially if there is a constitutional factor of the appropriate kind, to psychotic forms of illness". They state therefore that "one of the more obvious sources of emotional insecurity of early origin is the so-

called "broken home" and stress the fact that "the absence of one parent, besides producing a general sense of insecurity from lack of one source of affection, means the absence of an important figure with whom the child can identify himself as well as the absence of a source of training in sound habits". They consider the attitude and personality of the remaining parent to be of importance especially where, in such circumstances, it may be unhappy or neurotic or unstable. They add that "since emotional insecurity of some sort or another is a source of anxious habits of mind it might be expected that social conditions wider than the home itself would play a part, and in social conditions one has to include anything from financial insecurity to uncertain religious beliefs". On the whole, however, they consider that uncertainty is a more important factor than poverty.

As has already been noted in this series of 25 cases, early emotional insecurity was present in a large number of the patients and actual poverty was less commonly present. It is hoped to show, however, that a number of social and other environmental factors play their part, in the production of mental disorders related to childbirth.

Further, Henderson and Gillespie stated "the circumstances of life with power as its object may well

be productive of psychological illness", and that "such values are productive of a chronic anxiety, fear of failure and of inferiority feelings which are in fact an expression of a sense of failure to achieve the desired goals". It will be seen in studying the 25 cases in this thesis that this drive for power in some instances appears to play an important part in the production of mental breakdown at the time of childbirth, particularly when this desire for dominance had been of an intellectual nature, and in direct opposition to the emotional satisfactions of childbirth itself.

Henderson and Gillespie quoting Jacobs stated more specifically in relation to puerperal psychoses, that unless predisposing and precipitating factors were present, that even with a septic puerperium, breakdown was not likely to occur. They listed as the particular precipitating factors, aversion towards childbirth, a neurotic attitude towards motherhood, based on experience in the parental home, and an unsatisfactory married life. Further, they considered that the husband's attitude towards the pregnancy was not enough appreciated in relation to its effect on the woman.

In the last twenty to thirty years many authors have discussed the various precipitating factors which they consider to be important in the production of mental illness in relation to childbirth. Bourne, in 1924, felt that the character of the labour,

i.e., whether it was normal, difficult or complicated, did not in itself play a significant part in the production of breakdowns following childbirth. In 1926 Kilpatrick and Tiebout said that although psychical and physical factors played a definite part, they did not determine the type of reaction. In the manic-depressive cases they felt that psychic factors were the most important and determined to a large extent the onset of the illness. In favour of this they noted out of 27 cases of depression, there were 18 multiparae none of whom had had a previous puerperal breakdown. It is a pity that they did not quote more facts about these cases to show whether there was a change in the psychic factors between normal and abnormal pregnancies. They thought that as in seven of all their cases in which the psychosis started in pregnancy six were depressions, that this favoured the supposition that situational elements were significant. Apart from the depressions they stated that the manias showed no outstanding psychic determinants. They further added that the onset of schizophrenic illness in relation to childbirth usually occurred late in life, therefore suggesting that childbirth played a significant part by virtue of the fact that they had survived many stresses and strains without breakdown.

In 1928 Saunders thought that disappointment over the child's sex might play a part with possible tendency to react with obsessional over-compensation.

She further noted that if childbirth acted as an infringement on the mother's career that this too might precipitate an illness.

In 1933 Hall and Mohr studied the pre-natal attitudes of primiparae in 66 expectant mothers and noted in these apparently normal women many doubts and fears towards pregnancy and the child itself. The majority of these women showed that the pregnancy was unsought and in only twenty-two was it definitely planned. Although in the first instance the pregnancy was fully acceptable to only eleven, forty-one became reconciled to the pregnancy later and only fourteen remained unreconciled to it. In sixteen of their total number of cases the father objected to the pregnancy. There were financial strains in twenty-eight of the cases, hereditary factors in sixteen, marital conflicts in thirteen, fear of pregnancy and delivery in seven. Superstitions and anxiety about marking were present in thirteen and illegitimacy, bigamy, forced marriage, etc., in six. Five showed racial or religious conflicts while physical complaints were present in five, parental disapproval in four, dislike of children in two. There were fears as to the effects of birth control in two, and other disturbing preoccupations in relation to delivery - care, diet, clothes, etc., in a small number. Some feared that their rejection of pregnancy would reflect in the child's behaviour, and some showed emotional immaturity and over-dependence on the

parental home, whilst others apparently derived their dislike of children from home attitudes before marriage.

Although it would appear from this that many of these women might have been expected to break down following childbirth, if adverse life situations or faulty attitudes were important, Hall and Mohr gave no indication that this in fact happened. If they did not break down one is left to postulate why this was so. Firstly, there was no description of the personalities of these patients, nor was there any evidence whether more than one of the factors was present in any one individual. These two points might be considered to be important reasons why there was no break down. In addition there is no record of possible adverse constitutional factors. Lastly, of course, the fact that these women were included in this survey, and as a result of it, were given help and advice during pregnancy, may not only account for the fact that they did not break down as a result of such a variety of adverse circumstances, but might also be considered as a reason why early recognition of these difficulties could well be a powerful factor in the prophylaxis of mental disorder occurring at this time.

Harris, in 1936, studied 45 cases of mental illness associated with childbearing and considered that in addition to the factor of childbirth itself, other important aetiological considerations were as follows. In the manic-depressive group of cases which were ten in number, he noted a degree of mental defect in two; over-work, under-feeding or illness leading to general debility, in three; illegitimacy in one; an unfaithful husband with resultant rejection of the child in one; worry over another child's illness with resultant rejection of a further pregnancy, in one; a breast abscess leading to toxæmia, in one; while in three nothing abnormal could be noted. In his delirious type, of which there were eight, in one there was a positive family history, and in another the mother was single and her fiancé had deserted her. One was considered to have an unstable personality and in another there were money difficulties or cessation of lactation after seven days. Two were worried about the cessation of breast feeding and one had a congenital mental defect. There were fourteen schizophrenic cases in his group, and of these two showed a psychopathic family history; two showed mental defect; one had schizoid tendencies; one had an extra-marital pregnancy, one had financial stresses, two were single, one husband was unfavourable, one had parents who did not accept the husband, and in one there was no abnormal factor noted.

This paper seems to indicate that in the majority of cases of whatever type, some possible precipitating factor could be found, either in the heredity, the personality, or in the environment.

In 1937 Karnosh and Hope, in assembling statistical data on psychosis associated with childbirth, showed that their frequency was heavily influenced by constitutional social factors, although they stated that complex endocrine imbalance could not definitely be eliminated. In support of their contention that social and economic factors play an important part, they demonstrated that during the economic depression in America the incidence of puerperal psychosis increased rapidly and was out of proportion to the general trend of female admissions. This observation was similar to that of Esquirol almost a hundred years earlier when he wrote about the same disproportionate increase at the time of the Napoleonic wars. Karnosh and Hope thought, in women of cyclo-thymic disposition a delirious mania following childbirth, might lead to increased frequency and easier tendency to manic-depressive cycling even though subsequent pregnancies did not occur.

In 1938 Hirst and Strousse in studying one hundred normal pregnant women noted that 75% showed anxiety from economic stresses, 7% showed anxiety on account of difficulties with the husband, 10% showed anxiety attributable to other members of the family, and 16% showed phobias and worry over

the ill-health or death of near relatives, or the possibility of having mentally defective children.

Also in 1938 Fagan noted that three factors seemed to play a part in the production of breakdowns related to childbirth. The first factor was a constant or recurrently annoying experience which served to alter the personality to a discernible degree, secondly a nervous system under-par, and thirdly pregnancy itself. In three cases which he quoted, in one there was marital loneliness, social and economic circumstances were difficult and there was a family history of nervous instability. In a second case the patient was an adopted child; the adoptive parents disapproved of the husband with resultant anxiety in the patient during pregnancy, and they then refused to acknowledge the infant's birth. In this same case there was a second breakdown a year later through inability to accept responsibility for two children, and a third pregnancy which had to be terminated because of outbursts of screaming on the part of the patient. The third case became grossly upset in relation to some African knives hanging on the wall and following their removal settled down normally.

Piker, also in 1938, noted that pregnancy might well provide, in a variety of ways, the precipitant that would crystalise any potentially existing departure from normal. After considering constitutional factors, personality development and physical diseases

as possible factors in the production of a breakdown in these patients at this time, he went on to say that a fourth, but by no means less important factor, was the stresses and strains which were incidental to the attaining of maturity. This latter necessitated an assumption of independence, acceptance of responsibilities and an active participation in a competitive existence, of which they were incapable. He pointed out that one must always consider the total picture which the patient presented. In spite of the fact that childbirth in itself should be considered as a normal process, one should not forget that pregnancy and its sequelae do bring about profound although transient physical and chemical changes in the individual. In addition he emphasized that, the mental experience of childbearing and its multitude of possible emotional ramifications was by no means negligible.

McGeorge in 1938 quoted as aetiological factors, whether in depressive confusional cases, absorption of toxins, the exhaustion of parturition; hereditary or personal predisposition to neuropathic reactions as well as psychological factors. The psychological factors that he quoted as being important in the development of mental disorder in pregnancy, were intemperance, unemployment, neglect and privation, sudden bereavement, marital unhappiness or infidelity; fear, stimulated by alarming comments of friends,

shame in the case of an illegitimate pregnancy; anxiety in the case of an elderly primipara to whom the birth of a living child was very important, and a similar development of anxiety in relation to the multipara who has a series of miscarriages.

In 1939 Haworth in her series of cases mentioned two, where malnutrition owing to financial difficulties resulting from the husband's unemployment, seems to have played a part. In another of her cases the husband suffered from an anxiety state, and there were mentally abnormal relatives living with two of her other patients. Five of her total number were having illegitimate babies. She noted that the incidence of puerperal psychoses was higher in rate-aided patients and assumed that malnutrition and cramped quarters in this type of patient might be responsible for this higher incidence.

In 1939 Fishback stated that he thought illegitimacy in itself was not important, but demonstrated that 30% of his cases showed marital problems, financial worry, fear about difficulties in labour or the possibility of a Caesarian section, dislike of motherhood or illness or death of near relatives.

Cruickshank in 1940 after noting the importance of a bad heredity or unstable personality, in the development of mental illness at this time, stated that the chief aetiological factor was pregnancy itself and that toxæmia or exhaustion played a part

in the production of illness in a proportion of these cases. There were a number, however, which showed evidence of a primary toxic focus or exhaustion, either in physical status or in the type of psychiatric syndrome and concluded from this that the aetiological factors must be largely psychogenic in these cases. He listed as among the important psychogenic factors in his series of 84 cases, economic difficulties, conjugal disharmony, illegitimacy, fear of labour, added domestic responsibilities, stillborn children and so forth. He felt that all of these led to an unhealthy mental status during the gestational period or anxiety in the puerperium. On the whole, however, he felt that because delirium was a feature of a large percentage of the psychoses occurring in relation to childbirth, a toxic or exogenous process must nearly always be considered and the resultant mental illness could not be fully explained away on the basis of psychological conflict. In addition, although he stated that there was no evidence to sustain such a belief, he thought that endocrine disturbances might also play their part.

In 1941 Kraines noted that pregnancy was only a precipitating factor and cited instability of the previous personality, or toxic-infective factors as playing a part. In addition to these, he felt that further reasons for a possible breakdown, might be an undesired pregnancy, with resultant indifference or hostility to the child, or a feeling of inadequacy

and inability to cope with a child in those cases who wanted one.

Wick, in 1941, stated that according to most authors psychogenic disorders and personality difficulties were the most important producers of mental illness at this time, and he himself in his cases noted that additional stresses, either physical or psychic, which were incidental to pregnancy, were important. He quoted illegitimacy, worry over finance, feelings of inability to care for the child or disagreements with a mother who tried to rule the patient's marital life, were all likely precipitating causes.

Hinson, in 1942, noted that emotional discomforts or anxieties were more important than any physiological disturbances in the production of mental illness following childbirth.

Jones, also in 1942, expressed the opinion that a woman's reaction to childbirth was predetermined by elements in the earliest development, which might be completely unknown to her.

Ordway and MacIntyre in 1942 felt that the stresses of present day life in these cases were not greater than that in the average American family. However, they noted that eighteen of their forty-five showed conflict about pre-marital pregnancy, hypochondriasis, poor adjustment to environmental conditions, an unwanted baby, too rapid or ill-placed pregnancies, induced abortion, financial stresses,

incompatibility between husband and wife, feelings of inadequacy about assuming the responsibility of motherhood or a previously sheltered life without emancipation from the parents. In cases presenting these difficulties they regarded pregnancy not as a true aetiological factor but as a precipitating one which was super-imposed.

Ian Skottowe in 1942 thought that there were always additional causal factors other than child-bearing. In two-thirds of his cases there were bodily and mental strain arising from childbearing, bodily strain being predominant in confusional states and mental strains commoner in affective disorders. Mental strains were present in ²⁰/₂₆ of his cases and in 12 these were specially related to the pregnancy. He cited as examples of these strains anxiety over the fate of the child, infidelity of the husband, frigidity or love for another man. In the remaining third extraneous stresses either bodily or mental were present - the mental ones being economic anxiety, illness and death of near relatives, conflict over homosexual urges and masturbation.

Jacobs in 1943 felt that in addition to pregnancy itself other precipitating factors, either psychological or physical, were required to produce mental breakdowns in relation to childbirth. She stated that the importance of psychological factors arising from environmental influences was proved and quoted

as examples of these influences, aversion to childbirth in general or this child in particular; neurotic attitudes to marriage based on experiences in the parental home; an unsatisfactory married life; the absence of the husband; neurotic behaviour of the husband towards pregnancy; or inferiority feelings in the fourth decade related to the menopause and sexual difficulties.

Schmidt on the other hand in 1943 stated, that there was no record of post-puerperal psychotic patients ever developing a subsequent psychosis from any other stresses and strains of life, therefore attributing the whole thing more or less to pregnancy itself. This opinion, however, seems to be held only by Schmidt.

Stewart in 1943 noted as important factors, conjugal maladjustments, economic stresses, strain and worry, the responsibilities of marriage and an immature attitude towards these responsibilities. In addition he noted some physical diseases such as syphilis or alcoholism and avitaminosis, as playing a part as well as endocrine disturbance. He pointed out that a fuller history of the family background from the obstetrician should include consideration of the marital status, the sex life, the economic situation, the family burdens, concern over elders and difficulties with upbringing of the other children.

Chapman in 1943, discussed the importance of environmental factors in the production of mental illnesses related to childbirth, and thought that changes in the environment or ability to adapt to these were necessary for a good prognosis. She noted frequent irregularities in the home situations of puerperal schizophrenic cases. This author quoted Roland P. Mackay as stating that "most of the patients seen in a large general hospital with post-partum psychoses have psychogenic factors as the basis of the psychosis and that if the home situation was adequate and stresses there alleviated, the patients would get along very well".

Von Hagan in 1943 stated that mental illness following pregnancy "primarily depends on the constitutional make-up of the individual although the precipitating factors are as yet unknown". Although nobody would deny the importance of constitutional make-up of the individual it seems strange that Von Hagan, writing in 1943, should say that precipitating factors are as yet unknown whereas on the other hand Jacobs says that the importance of environmental influences in the production of mental illness at this time has already been proved. Certainly the number of other writers that have quoted difficult environmental circumstances as being important would indicate that Jacobs' statement would be more nearly accurate than that of Von Hagan.

Cohen in 1943 pointed out that pregnancy and parturition takes nearly a year of the patient's life and that during such a time there is ample opportunity for psychological factors to be operative. In quoting Gilbert he says, 'to set up a list of problems as specific to pregnancy would be to isolate a certain period in the life of an individual, limiting cause and effect to the mere months of pregnancy.' Cohen also pointed out that pregnancy was the most momentous experience in any woman's life and that her mental adjustment to it, happy or unhappy, would determine her health, spiritual as well as physical. He adds that the same events were different to each individual and as already mentioned in the section on Personality, different women regard pregnancy in a different light. Some of them regard it as an encroachment of the world upon them and some as an extension of the ego, some with an aggressive, rebellious attitude towards it, others submissive, and, on these attitudes depends the likelihood or otherwise of a breakdown. In many women he noted fear of pregnancy and the possibility of death or apprehensiveness over the fate of the child.

La Loggia in 1947 stated that maternity was a precipitating factor in itself and that psychological changes occur normally in pregnancy, lactation and the puerperium.

The 25 cases in this thesis will be studied with particular reference to the possible precipitating factors in the form of adverse life situations. It

seems that the simplest thing here is to divide the multiparae and primiparae into separate groups. This is done for two reasons, firstly that the primiparae should present a much more clear-cut picture of the operation of any adverse life situations which may be present. Secondly many of the multiparae had had previous breakdowns in relation to childbirth and it was considered that it might be of interest here to try and show that there were definite changes in the life situations where there had been a breakdown in relation to childbirth and a normal pregnancy in the same patient. In dealing with the primiparae although it is anticipated that the effect of adverse life situations may be more apparent, it is nevertheless impossible to separate entirely from the adverse environmental factors and their effects the personality, structure of the individual and the heredity with which that individual is endowed. It is proposed, however, to attempt at this stage to isolate adverse life situations and reference to the final table will show those cases in which there was either a poor heredity or an unstable previous personality present in addition to the adverse life situations. In order to study the difficulties which may have been present in each of these individual patients, it is proposed to divide the factors into various groups while within the main groups there will be further sub-divisions. Each case will then be dealt with under the broad headings only,

each sub-division in that group being considered at that time in that particular patient. The following table shows the broad headings and the sub-divisions to be used in analysing the 25 cases.

TABLE 9.

A. MARRIAGE.

1. Husband (a) Unstable personality
(b) Actual mental illness.
2. Maladjustment (a) Sexual
(b) Other.

B. ATTITUDE TO MOTHERHOOD.

- (a) In general (including fears related to bearing and rearing child)
- (b) In this particular pregnancy.

C. DELIVERY.

- (a) Inconsiderate Nursing
- (b) Tears
- (c) Bad anaesthesia
- (d) Prolonged labour
- (e) Prematurity or postmaturity.

D. FEEDING DIFFICULTIES. Due to:-

- (a) Physical reasons
- (b) Psychological reasons.

E. SOCIAL FACTORS.

- (a) Overcrowding
- (b) Bad accommodation
- (c) Living with in-laws
- (d) Difficulty with neighbours
- (e) Moves at inopportune times
- (f) Financial difficulties
- (g) Overwork.

PRIMIPARAE

A. MARRIAGE. (including Husband (a) & (b) and
Maladjustment (a) & (b).)

Case 8. J.W. The husband in this case was the same age as the patient and although not unstable, was over-attached to his own mother who disapproved of the marriage. He was more intelligent than the patient who was acutely aware of this fact throughout the marriage. This was further emphasized by his insistence upon teaching her about current affairs, etc. The result was that she felt strongly that the domestic and childbearing side of the marriage had to be excessively efficient to balance the intellectual discrepancies between them. Her miscarriage in March 1947 was very disturbing, and regarded by her as a failure on her side of the marriage. The fact that she apparently had some doubts about marriage to this man at all is evidenced by the fact that she showed regrets regarding the marriage following separation in the early days of their marital life.

Case 4. E.H. This patient met her husband at an early age and they appear always to have been well suited to each other. The husband was three years older than the patient and said to be rather highly strung, but from his behaviour in difficult situations it would seem that he is basically a fairly reliable and stable personality. The fact that he was no more enthusiastic than the patient about having children probably made it possible for the marriage to remain well adjusted on the whole. Sexually there were some minor difficulties, the patient not always reaching orgasm and this seems to have been largely related to her anxiety regarding pregnancy.

Case 3. R.W. This patient had had a somewhat varied sex life before her marriage, usually with attachments to men older than herself. The husband was 13 months older than the patient, the child of Jewish-German parents - an undemonstrative, hysterical mother, to whom he was over-attached, and an apparently abnormal father whose harsh treatment of him in childhood was outstanding. The husband's personality was anything but stable; he was a rigid and obsessional individual, insecure himself and unable to accept full responsibility in the marital situation. The result of this was that the patient always felt that she had to be the one to make allowances and bear the major loads of the marriage. This she was able to do satisfactorily until after childbirth. The reason for their marriage in the first place seems to have been rather inadequate and was based largely on the necessity for obtaining a British passport for her to enable to escape from Nazi persecution in Germany. Following her marriage

and during her husband's absence in the Forces, she became seriously involved both sexually and otherwise with a youthful intellectual. This relationship persisted for many years and culminated in his going to live with her husband and herself up to the time of the patient's pregnancy. Although she maintained that there was never any doubt as to who was the father of the child it seems that she was having intercourse with both her husband and this man until six weeks before she became pregnant. She had considerable guilt about this relationship of which her husband was apparently unaware.

Case 5. J.S. In this case the child was illegitimate and the patient felt a great deal of shame in relation to this. She met the father of the child when she was 17½. He was an unstable individual, a heavy drinker dominated by and over-attached to his own mother who refused to countenance the possibility of marriage. Between meeting the father of her child and becoming pregnant she had two or three affairs with other men but seems to have been unable to maintain a stable adult relationship with any of them. The fact that she lived in a small village meant that her pregnancy caused a good deal of scandal which was not helped by the attitude of the father of the child. This necessitated her going to London for the delivery, far away from her people, and the total situation in a personality which in any case was not a stable one, must have been extremely disturbing.

Case 6. M.H. This patient also appears to have had difficulty in forming an adult relationship with men. She had a succession of boy-friends but was never able to stick to any of them for long. She was attracted by the glamour of foreigners and had friendships in turn with an Italian, an Egyptian and a Spaniard, the latter of whom she finally married. She had rather an unsavoury affair with the Egyptian prior to marriage which culminated in her being attacked by him with a whisky bottle and left the patient with severe scars, in relation to which she showed a great deal of guilt and shame. The Spaniard whom she married when she was 19, was 9 years older than herself and appears to have been a kind, considerate and stable personality. She was converted to Roman Catholicism with no misgivings. The marriage, however, was not successful,

particularly in the sexual sphere. The patient disliked intercourse, was frigid, and following the birth of her only child refused to have further intercourse. She appears to have managed the domestic side of marriage only so long as they were living in hotels abroad but when forced to face the realities of running a home, inadequate accommodation, etc., on her return to this country, she rapidly broke down and has continued to do so at intervals.

Case 9. M.D.H. There was little abnormal about this patient's relationships with men or with her husband in particular. Her husband was her first boy-friend whom she met when she was eighteen, and to whom she became engaged when she was twenty-one. The husband was a fairly stable, cheerful, outgoing personality. He is reported as having been a mother's boy owing to ill-health in childhood, but in adult life seems to have compromised satisfactorily regarding his relationship with his mother. They were separated for some time during the early years of their marriage owing to the war, but the relationship was resumed happily on the husband's return. The fact that they lived with the patient's mother-in-law in a separate part of the house seems to have been accepted quite satisfactorily by the patient. This was more particularly the case as the patient's own unsatisfactory home background in her adolescence resulted in her going to live with the woman who was subsequently to be her mother-in-law, and, she accepted her more or less as her own mother.

Case 2. I.M. This patient's attitude to men seems always to have been a little uneasy. She was an attractive woman and had a number of boy-friends but would always break off the relationship with any of them when they suggested marriage or became too serious about her. She seems to have anticipated physical assaults upon herself even in the most casual relationships where no such thing happened. She did not experience difficulties to the same degree regarding the possibilities of marriage in relation to the man she ultimately married. This seems to have been due to the fact that he was neurotic and had himself to be treated by group psychotherapy. She felt therefore that he was more likely than most people to understand her own diffidence. Even so she behaved in rather a strange way at the time of her engagement, suddenly becoming alarmed by the possible responsibilities of marriage so that it took three hours to persuade her to put on the engagement ring which she actually lost afterwards. The marriage itself appears to have been reasonably happy but sexually she was never at ease, frequently did not reach orgasm and remained tense and rather anxious in relation to sexual intercourse.

Case 10. B.E. This patient's relationships with men were always a little difficult. She was extremely self-conscious about her deafness and shortsightedness and on this account may have wondered whether she would ever marry. In fact the marriage was arranged by the family and as far as one can ascertain, seems to have been accepted by the patient, particularly as the family was a Jewish one in which marriages for some of the other siblings had been arranged by the parents. The husband was seven years older than the patient, and, although a reasonably stable individual, his sarcastic manner, especially directed to the patient's physical disabilities at times, made her mildly unhappy. The fact that the husband did not have time to buy the engagement ring but allowed the patient's mother to do so, would seem to indicate that this could scarcely be described as a love match. The sexual side of the marriage was reasonably satisfactory.

Case 11. M.J.C. This patient, owing to evacuation during vital adolescent years, seems to have suffered from lack of parental control. During her evacuation she was wild and destructive and indulged in petty pilfering as has already been described under an earlier section. Apparently in the nature of an experiment in sexual matters, she had intercourse with a soldier whom she met when she was fourteen. She was always rather "highly sexed" and had a lively interest in the processes of reproduction. She first met her husband when she was seventeen and started to have intercourse with him a year later. This in fact would have happened sooner had the husband not been too inexperienced and shy to buy contraceptives. The husband was four years older than the patient, a student of music, living on a small grant following his discharge from the services. To outward appearances he would have liked to give the impression of being a man of the world, but was obviously as youthful and undeveloped as the patient herself. There was a great deal of parental opposition on the patient's side of the family to their marriage, culminating in a Court case which ended in favour of the parents. It was only when the husband's people took a hand in the matter that the marriage was finally permitted. Although one could not describe the marriage as being irretrievably maladjusted, it would appear to have suffered as a result of the immaturity of both the partners concerned in it. Sexually the patient's demands were greater than those of her husband which frequently resulted in her not being satisfied and masturbating. Part of their sexual difficulties were no doubt due to the husband's inexperience. Apart from the sexual side

of their marriage the patient appears to have been intolerant of her husband's ideas and preferences which resulted in a number of rather childish and violent scenes.

Case 7. S.R. The husband in this case was the same age as the patient and appears to have been a stable, capable personality if somewhat over-dependent on his own mother. The marriage was a happy one and adequately adjusted sexually.

Case 1. A.V. This patient met her husband when she was twenty-two and nine months after their first meeting they started to have pre-marital intercourse. They married four years later. The husband was three years older than the patient, an unstable man with obsessional features. Three days after their marriage he formed a liaison with a woman at his place of work which lasted for six months. The patient heard about it through an anonymous letter, was very upset, and threatened to leave him. Although when the affair ended they apparently settled down reasonably well they remained poorly adjusted sexually and the patient was frequently unable to reach orgasm. The husband seems to have been inconsiderate in other ways and left the patient at home alone during an illness. The husband's brothers lived at various times in the house and the kindness and consideration of one of her brothers-in-law seems to have resulted in the patient feeling more affection for him than for her husband. This relationship no doubt became more important to the patient following her husband's call-up to the R.A.F. even though she was still able to see him fairly frequently. This state of affairs continued up to the time of her pregnancy.

B. ATTITUDE TO MOTHERHOOD.(including (a) and (b).)

Case 8. J.W. This patient was eager to have children, and this particular pregnancy was anxiously awaited as a completion, so to speak, of her side of the marriage relationship. The fact that the child was born with a congenital deformity of the eye, when in fact she had anticipated a particularly perfect child, no doubt resulted in strong feelings of rejection of the child.

Case 4. E. H. This patient's attitude to motherhood in general has already been discussed in conjunction with her relationship to her mother. The mother, as has already been stated, advised the patient strongly against childbearing on the grounds of its "messing up one's inside" and the patient and her husband

had decided never to have any children. The patient therefore had great difficulty in accepting the pregnancy and considerable doubts about her own lack of maternal instincts, fearing that she would not know how to manage the child. She also regarded it as being the possible means of interfering considerably with her own activities in life.

Case 3. R.W. This patient never wanted to have any children it seems, due to the fact that she regarded intellectual activities and pursuits as being infinitely more important and thought that the child would greatly interfere with these activities. She regarded herself as lacking in maternal instincts and felt the child would be critical of her inability to know the right things to do for it. Apart from her general attitude to the pregnancy, in this particular instance there was, living in her home, a man with whom she had had a close intellectual liaison for many years and at this time was also having sexual intercourse with him as well as with her husband. Although she was apparently convinced that certain time factors made it impossible for the child to be other than her husband's, there was a certain amount of dubiety about it in her own mind, so that this particular pregnancy was even less desirable to her.

Case 3. J.S. This particular patient seems to have wanted quite genuinely to have children. As the pregnancy in question, however, was an illegitimate one, she was extremely guilty about it and there was no doubt that this child was not a wanted one.

Case 9. M.D.H. There is no evidence in this case that the patient did not want to have children and she was extremely pleased when she became pregnant with the child whose birth was followed by the present breakdown.

Case 6. M.H. This patient certainly never wanted to have children, disliked the idea of pregnancy and the distortion of her body during that time. She felt throughout her pregnancy that somehow she could not possibly bear the child but could give no adequate reason for this feeling. She did not anticipate being able to manage the child and feared the idea of labour. It is interesting to note that when she had plenty of help in dealing with the child and household affairs during her time abroad, that she managed reasonably well and apart from her puerperal breakdown had no further mental illness until she was required to accept the full responsibility for domestic duties and the child as well.

Case 2. I.M. This patient's attitude in relation to accepting responsibility was emphasized and perpetuated by having a child. Although she overtly accepted her pregnancy she remained afraid of the time when she would not be able to manage the child. It seems likely that there was never complete acceptance and her resentment was considerable when the doctor who examined her because of her infertility, told her that she had not tried hard enough to have a child. In this case the rejection of motherhood in general seems to have been more or less an unconscious one.

Case 10. B.E. This patient seems to have accepted the idea of motherhood in general and although she does not seem to have actively wanted a child particularly herself she willingly accepted it as part of her married life.

Case 11. M.J.C. In this instance the patient was anxious to have children although she was slightly frightened at the prospect of labour. This particular pregnancy, however, occurred sooner after marriage than she wanted and her own immaturity may well have made her feel that she was not yet ready to have a child of her own.

Case 7. S.R. This patient wanted children and planned the pregnancy in question. It does not seem possible to show that there was any rejection of, or faulty attitudes to, motherhood in her case.

Case 1. A.V. In this particular case the attitude to motherhood does not seem to be very clear cut although it is possible that her dislike of work and her enjoyment of going out may have made her rather doubtful regarding the responsibilities of having a child. She did, however, want the pregnancy in question.

C. DELIVERY (including (a) to (e).)

Case 4. E.H. In this instance the adverse circumstances under which this patient had her baby no doubt played a part in the development of her illness. The child was three weeks over-due; when she was sent into hospital in labour she arrived to find that the doctor could speak no English and the nurse could speak no Spanish so that the means of communication between them was somewhat limited. The adverse reports on this Venezuelan Hospital were

only too well known to the patient before her admission and confirmed during her stay there. She was left practically unattended during the birth and sustained a bad cervical and perineal tear. She worried constantly about lack of asepsis and the dirty conditions prevailing in the hospital. She had to have a number of external and internal stitches which upset her very much. The night after her delivery she was awakened by a native woman screaming in the next bed. She was rarely washed properly and her stitches became infected. She was discharged from hospital too soon and thereafter received contrary instructions from nurses and doctors whenever she went to the hospital for help. She did not do well after her discharge and had to have constant treatment for the infected stitch wounds. Every day she had to go to the hospital to have liver injections, frequently waiting long periods before she was seen. Her husband sent her to Barbados where she had to have a D & C done. She subsequently got a bowel infection and things continued to go awry.

Case 3. R.W. Two months before term this patient had an ante-partum haemorrhage and was forced to remain in hospital against her will thereafter, until the birth of the child. The patient was left alone during the birth and was much upset by this.

Case 5. J.S. This patient appears to have been upset and frightened during labour and was unable to make use of the gas and air owing to her fear. As a result of this she sustained a fairly severe tear. There was difficulty in separating the placenta and she lost 30 ozs of blood. On the third day of the puerperium she had a rise in temperature which lasted twenty-four hours.

Case 6. M.H. As this patient was not admitted to hospital here until some years after the occurrence of her puerperal illness the facts regarding her delivery could not be confirmed. Her husband, however, reported that her labour was quite uneventful apart from a tear.

Case 9. M.D.H. During the pregnancy the baby was found to be a breech presentation and two or three times had to be turned. This does not appear to have upset the patient unduly and the delivery was a vertex one. The labour was severe but was fairly normal apart from being long and that the patient sustained a tear.

Case 2. I.M. This patient's pregnancy and delivery seem to have been fairly normal except that she had a breech presentation and delivered herself spontaneously and unexpectedly whilst unattended. This does not seem to have upset her apart from making her anxious as to whether the child might have been injured.

Case 10. B.E. During the later months of pregnancy this patient developed a toxaemia, was admitted to hospital and induced three weeks before term. The birth, however, was quite straightforward.

Case 11. M.J.C. In this case the patient went into hospital for four days at the expected time of her delivery. She did not go into labour at that time herself but was much upset by another patient groaning and screaming in the same ward. She was informed that she had a "high head" and at the same time they asked whether she would be examined for an "M.D. examination", and she got the idea that she was rather a rare case. She finally went into labour at home some fortnight or so later during which time she had been getting anxious about the lateness of the onset of her labour. She appeared shivering, apparently nervous, when she was taken into hospital the second time, and was over-active and anxious during labour. She sustained internal and external tears when the baby was born too quickly. She had a considerable haemorrhage after the birth and was anxious when the baby was not brought to her until twenty-four hours after its birth because she heard the doctors saying that it was not breathing properly and was being given oxygen.

Case 7. S.R. This patient was admitted to hospital a week before delivery. Although she was delivered without complications, on the whole during her stay the nursing staff were very unsympathetic to her and on one occasion when she asked something she was told that "as a mother she ought to know".

Case 1. A.V. This patient had a straightforward delivery apart from sustaining a severe tear. There was a shortage of staff in the hospital at that time and she was frequently given contrary instructions by sisters and nurses so that she felt she never could do the right thing. On two occasions when she was incontinent she was made to clean up herself which upset her very much.

D. FEEDING DIFFICULTIES. (due to (a) and (a))

Case 8. J.W. Following her discharge from hospital this patient breast fed her baby but it lost weight and she was much upset when relatives remarked upon its small size. As her illness came on about that time in any case breast feeding was terminated.

Case 4. E.H. This patient had great difficulties with breast feeding and the baby would not take to the breast properly after its birth. Following her discharge from hospital the child cried constantly and never seemed satisfied after feeding times. Finally the patient's milk disappeared altogether and she was told to put the baby on the bottle. This caused a great deal of difficulty as in the small place where they lived in Venezuela there were none of the usually accepted milk foods to be had, and those that were available had the instructions given in Spanish only so that the patient was uncertain of the quantities. The baby lost weight steadily after its birth and although the patient took it back to the hospital again she obtained little help from them until ultimately the baby became so ill that it had to be admitted. Even after the patient's husband sent them to Barbados the baby did not do well. It developed bronchitis and again lost weight. All this caused the patient much anxiety.

Case 3. R.W. The baby in this case did not feed properly after birth and lost weight steadily. This continued after its return home. The patient was unusually determined to breast feed the child and when her milk became rather less, it increased her fears about not being able to do so. It was only with a considerable struggle that the patient finally agreed to the baby being weaned. Even after it had been weaned she continued to worry about the cleanliness of the bottles and teats, was preoccupied with flies and germs, and was never satisfied unless the teats produced the same number of drops from them as the book said. Often she would have to count out the number of spoonfuls of milk several times because she was unable to be certain that she was doing it correctly.

Case 6. M.H. During the first week after delivery the patient successfully breast fed the baby, but by that time had become ill and was bitterly resentful about having to continue breast feeding. She was persuaded to do so, however, until three weeks after delivery when her milk failed entirely.

Case 2. I.M. There seems to have been no difficulty with breast feeding in this case until the child was three months old, when the patient feared that her milk was going to dry up and finally this in fact happened, by which time the patient had developed the illness for which she was admitted to hospital.

Case 7. S.R. Following her discharge from hospital a fortnight after delivery the baby cried constantly by day and night, giving the patient little sleep. She herself had cracked nipples which caused her much pain but in spite of this persisted with breast feeding the baby.

Case 1. A.V. Three days after the birth of the baby in this case the patient became markedly unco-operative in relation to feeding the child. There was no evidence that there was any actual difficulty and this seems to have marked the onset of her illness.

B. SOCIAL FACTORS (including (a) to (g).)

Case 11. M.J.C. In this instance the patient and her husband lived in an inconvenient, top-floor flat with two rooms and during the pregnancy the landlady threatened to eject them as she did not want to have any children there. They were quite unable to find anywhere else to live and were extremely anxious about the prospect of not having a roof over their heads. In fact the landlady did not implement her threat after the baby was born, but they were compelled to carry water up two flights of stairs and there was nowhere where they could hang the nappies out to dry.

Case 7. S.R. In this case the patient and her husband, following their marriage, lived with the patient's people, but as the house was rather overcrowded they were forced to move to the husband's parents. Here there was an eight-roomed house and out of that the patient and her husband were given only one room of their own in which to live. The mother-in-law cooked for them, or if the patient did so, was extremely critical of her, in addition to which the maternal grandfather also frequently interfered. The patient became very unhappy under these adverse circumstances, often being reduced to tears by the moody, short-tempered and domineering mother-in-law. It was shortly after moving into these conditions that the patient became pregnant. As the months passed the patient's relationship with her mother-in-law became worse and although she attempted to avoid quarrels at any cost and managed to keep most of her unhappiness to herself, there was a great deal of tension at this time for her. Added to this her own parents and her in-laws could not agree and she felt torn between them both.

Case 9. M.D.H. In this case the patient and her husband lived with the patient's mother-in-law, but the arrangement appears to have been fairly satisfactory, the young people having the top floor of the mother-in-law's house. In any case the relationship between the patient and her mother-in-law was such that one cannot postulate that this living arrangement played a very large part in her breakdown. There was some degree

of over-attachment of the husband to his mother, but this does not seem to have caused the patient much anxiety.

The findings related to the various headings dealt with under Adverse Life Situations have now been studied in relation to each individual case. The table overleaf shows the sum total of these findings in all the primiparae.

More detailed and tabulated information in relation to each patient may be obtained from the large chart on Page 137a.

<u>Social Factors</u>	<u>Marriage</u>		<u>Attitude to Motherhood</u>		<u>Delivery</u>		<u>Feeding Difficulties</u>
	<u>Unstable Husband</u>	<u>Sexual or other mal-adjustment</u>	<u>Fear of responsibility of managing children</u>	<u>Child unwanted</u>	<u>Fear of Labour</u>	<u>Inconsiderate nursing</u>	
2.(18%)	6.(55%)	7.(64%)	4.(36%)	5.(45%)	3.(27%)	6.(55%)	7.(64%)

It is of interest to note that in the eleven primiparae social factors appear to have played very little part in the onset of their illnesses. In all, there were only two cases where perhaps living conditions were not ideal, but even in these it did not seem particularly to affect the patients. On the other hand, sexual or other maladjustments in the marriage and feeding difficulties following delivery appear to have played the most important part; while inconsiderate nursing and instability in the husband are also significant. Attitudes to motherhood are important although somewhat less so than other factors, while fear of labour is of lesser significance. These, of course, are merely broad trends shown by these patients as owing to the small number of cases they cannot be considered statistically reliable.

Breakdowns Unrelated to Childbirth
in Primiparae.

Before passing on to the consideration of various life situations in the multiparae, study of previous breakdowns quite unrelated to childbirth, occurring in the primiparae will now be considered. Out of the total of eleven cases there were four who had had breakdowns outside pregnancy. Of these four, three broke down before pregnancy and only one had a breakdown following it. Firstly let us consider the three with breakdowns prior to pregnancy:-

Case 5. J.S. This patient had the previous breakdown under circumstances which seem to have been totally unrelated to any question of pregnancy, childbirth, marriage, etc. It occurred when she was in the A.T.S. and was apparently an hysterical illness directly associated with her inability to cope with the work required of her in the services. This breakdown occurred immediately prior to an examination which she had to sit and knew she would almost certainly fail. She was sent to St. Andrews Hospital, Northampton, where she remained from four to six weeks and was invalided from the Services on account of it.

Case 10. B.E. This patient had had two breakdowns similar in nature to the one occurring after childbirth, the first of which occurred at the time of her engagement. Her home had been robbed of some jewellery, the patient became depressed and worried that her mother had not told her husband that she was deaf. In this illness she became mute, was seen by a psychiatrist and the illness cleared up within two weeks. Following that, she was quite normal until a year later, on the anniversary of her wedding, she again had a similar breakdown lasting a fortnight. She was in fact pregnant at that time but unaware of it. She worried during this illness that her husband was supposed to have only one testicle and feared he might be sterile.

Case 1. A.V. In this instance the patient broke down four years after her marriage, with anorexia and depression and was treated as an out-patient at a psychiatric hospital. She recovered in seven weeks. No definite precipitating factor could be found for

this illness, but her marital situation was becoming steadily more unsatisfactory and it may well have been as a result of this that her illness occurred.

The following is the only case in this group who broke down after a puerperal illness:-

Case 6. M.E. This patient, who had lived most of her married life in hotels abroad, returned to England in 1943. She continued to live in hotels in this country until 1947 and remained well until she and her husband first had a home of their own in March 1947. A month later she had to be admitted to hospital because of depression, irritability, various aches and pains, and inability to cope with her household duties. At that time she had a number of hypochondriacal preoccupations regarding cancer, tuberculosis and insanity. She was given E.C.T. and gradually improved, finally being discharged from hospital four months later. She continued to find things difficult at home following her discharge but remained well until April 1949 when her brother was found to have tuberculosis and her child was also suspected of having a T.B. lesion. She again became anxious, depressed and worried about the inconvenience of her flat. She was finally admitted to hospital again and it was at the time of this last admission that her case was studied in full.

It seems therefore that of the three cases who had breakdowns before pregnancy, one appears to have broken down in relation to a difficult marital situation. The breakdowns of a second were related to her engagement, the anniversary of her wedding and the onset of pregnancy, and the third had a breakdown quite unrelated to marriage, childbirth, etc. The fourth did not have a breakdown before having a child but had two afterwards, at both times associated with inability to cope with the domestic situation.

To sum up the findings in the eleven primiparae an attempt is made in the following table to assess the relative importance of adverse life situations, poor heredity, unstable personality, or a combination of all three. Each case has the factors considered to be most important, marked alongside. Personality factors are shown as (P); Life Situations as (L.S) and Heredity as (H).

TABLE 11.
PRIMIPARAE.

With Previous Breakdowns	Without Previous Breakdowns.
J.S. (5) P.and L.S.	M.H. (6) P.
B.E. (10) H.	I.M. (2) P. and H.
A.V. (1) L.S. and P.	R.W. (3) P. " L.S.
	E.H. (4) P. " L.S.
	S.R. (7) L.S.
	J.W. (8) L.S.
	M.D.H(9) ---
	M.J.C(11) P. and L.S.

MULTIPARAE.

A. MARRIAGE. (including Husband (a) & (b) and Maladjustment (a) & (b).

Case 24. N.C. This patient met her husband when she was aged thirty. He was six years younger than herself, had had a fractured spine some years previously and as a result was lame. He, like the patient, was a Communist and editor of a Communist paper. They lived together for some time before they married and following their marriage things seem to have gone fairly satisfactorily at the outset. The patient had her first child quite normally in 1942 and it was following that, that they moved into a house to live with another married couple. When the patient was thirty-eight her husband had a nervous breakdown, was unable to work and the patient had to support him from her own private means. This breakdown lasted eighteen months and subsequent to that, he only worked spasmodically. At the time of his breakdown they practised mutual self-analysis during which process the patient discovered, that he was in love with the other married woman with whom they lived. It was not long after that, that the patient became pregnant with the child which caused the present breakdown. During her pregnancy the husband was unable to make a decision between either woman, resulting in violent quarrels, nor would he let her go to stay with a woman friend in America as she proposed to do. This state of affairs continued up to, and following, the time of her delivery with the present child, although it was not until three and a half months after her delivery that she actually found out that the husband was having intercourse with the other woman. It is interesting to note, in this case, that prior to marriage the patient had had at least one intense homosexual affair.

Case 17. R.E.W. This patient had several boy friends before she met her husband. The husband was the same age as herself, a stable personality, and the marriage appears to have been reasonably welladjusted both sexually and otherwise.

Case 23. W.S. The husband in this instance was two years older than the patient. They knew each other for three years before they married and in the early days the marriage was very happy - apart from the sexual side of it, the patient rarely, if ever, reaching orgasm. Throughout the years the marriage, however, became very unhappy. There were frequent arguments because the husband joined the Mens Club and enjoyed organising things there,

often leaving the patient at home alone. She herself had always wanted a home life but was unable to get him to see the importance of this from her point of view. Her reason therefore for wanting a second child seems to have been more or less as a compensation for her husband's frequent absence from home.

Case 22. A.S. This patient met her husband when she was fifteen and not long afterwards started having intercourse with him, although she regarded intercourse as something shameful. No contraception was used and she was terrified in case she should bring shame upon her mother. She did, in fact, become pregnant when she was eighteen and the mother-in-law to-be created a considerable scene, took her to a chemist and made her take drugs to produce an abortion. This was unsuccessful and in these circumstances the patient and her husband married. The husband was three years older than the patient and two years after their marriage he was invalided out of the Army on psychiatric grounds and treated in a mental hospital with E.C.T. He has never been able to provide a stable home for the patient who has been correspondingly resentful about it. Intercourse seems to have been satisfactory to the patient until after the birth of her second child.

Case 18. R.H. This patient met her husband when she was working on a Commercial Art course, both being employed in the same work. He was a year younger than herself and as insecure a personality as she. When she was twenty-six they started living together and continued to do so for the next two years. During the time they were living together she wanted to get married and he did not, considering the financial strain of children to be too much. Finally, however, she persuaded him to agree. The patient kept her husband for the first year of their marriage whilst he continued studying commercial art. Gradually the confidence which she had previously derived from him seemed no longer to be present. Her husband did not want children and all her pregnancies were only achieved after long arguments with him. With the birth of each child their marriage became more and more strained and difficult. Her husband refused to give her any help in the domestic sphere and felt that his own work was more important. In the latter years of their marriage quarrels became increasingly frequent and on several occasions he threatened to leave her. Sexually they appear to have been quite well adjusted.

Case 25. F.H. This patient had pre-marital intercourse before she met her husband as she felt it to be a means of keeping her boy friends. She always tended to avoid any relationship which seemed to be approaching the stage of marriage. She met her husband when she was twenty-eight and, unable to disentangle herself from a current love affair, she depended upon her husband to do so for her. During the time of her courtship she remained a semi-invalid with a neurotic illness and it was only when her fiance threatened to leave her that she agreed to marriage. They had pre-marital intercourse and married when the patient was thirty-four, only because, as already stated, her fiance would have left her otherwise. The husband was seven years younger than the patient and a stable personality. During the war they were separated for long periods which did not seem to upset the patient in the least.

Case 16. E.L. This patient met her husband when she was twenty, became engaged a year later and married the year after. The marriage was in a Protestant Church, though the patient was a Roman Catholic, and occurred three months after the death of the grandmother who had always said to the patient that if she lost her faith she would come back and haunt her. The husband had refused to adopt the R.C. faith, his father being particularly against it. The husband was two years older than the patient and very much over-attached to his own mother whom the patient rather resented. The marriage was not satisfactory sexually, the patient rarely reaching orgasm and intercourse frequently culminating in masturbation with guilt. The husband was called up and was away in the Services for a year during the war but was in this country, so that the patient was able to see him at fairly frequent intervals. It would seem that this patient never really considered herself properly married because the ceremony had taken place outside the Roman Catholic Church.

Case 19. V.P. This patient had pre-marital intercourse with a man other than her husband. He was five years older than herself and a married man with children. As a result of an isolated episode of intercourse the patient became pregnant. She was discharged from the Services on these grounds

and had a difficult and worrying time, up to, and following the birth of the baby. When she was twenty-five she met her husband, a man also five years older than herself. He was an only child, whose mother had died when he was two, he subsequently being brought up by an aunt to whom he was greatly attached. His marriage to a woman thirteen years his senior had come to grief after only a year. He was an unstable personality who had several changes of jobs. Apparently markedly lacking in affect and detached in his attitudes to other people, his main interests were tapestry sewing and vague oil paintings. For the sake of security only, the patient married this man when she was twenty-eight. The marriage on the whole was not a success. Sexually the patient appears to have been frigid and in addition to that found her husband's lack of affect and sense of responsibility extremely trying.

Case 15. E.D. This patient met her husband when she was seventeen. They went out for about four years together before they started to have intercourse, until at the age of twenty-four the patient became pregnant. She was terribly upset by this and there was a family upheaval and as a result the patient was married. The husband was a year older than the patient, a psychopathic personality with a violent temper and no sense of responsibility. To start with the marriage was reasonably happy and it was only as the responsibilities of an increasing number of children were added, that difficulties really started between them. He would constantly return home drunk and spend more money than they had; he became extremely jealous and accused her of having intercourse with other men. The marital situation seems to have become only really intolerable after the birth of their third child.

Case 14. M.B. This patient met her husband when she was eighteen and after a long courtship they married when the patient was twenty-nine. The husband was four years older than she, a stable personality and the marriage at first seems to have been quite happy. It was not until after she had had two children, that she began to feel that she could not cope with any more responsibility. As a result of this she became increasingly fearful of having intercourse, in case she should become pregnant again. She often did not obtain satisfaction from intercourse and was constantly under tension because the only means of contraception was coitus interruptus, which was often practised not very satisfactorily.

Case 21. A.K. This patient met her husband when she was nineteen. He was three years younger than she and was a step-cousin. He was rather a strict and unimaginative character although not markedly unstable. They became engaged when the patient was twenty-one and a year later they married. The marriage seems to have been fairly satisfactory both sexually and otherwise. A year after marriage the husband was called up and ten months later, when the patient was four months pregnant with her first child, he was sent overseas. In spite of these difficulties the patient remained well. On his return from the services in 1945 they resumed their married life reasonably smoothly, but a year later the husband fell in love with the patient's best friend and there was considerable unhappiness at this time, particularly as a few months later the patient found that she was pregnant. She had a spontaneous miscarriage and to all intents and purposes this seems to have "brought her husband to his senses" and she denies having had further doubts about his fidelity during the following year, when she again became pregnant with the child that caused her present breakdown.

Case 13. M.A. This patient met her first husband when she nineteen. He was three years older than herself. Their courtship lasted three years and they married when the patient was twenty-one. The marriage seems to have been reasonably well adjusted, except in the sexual sphere where the patient was always frigid. After the birth of the first child three years later, the patient developed a depressive illness and the husband seems not to have understood the nature of her illness and thought that she wanted to leave him. On these grounds the marriage broke up. Twelve years later she met her second husband and after a courtship of some months they married. He was seven years younger than the patient and their marriage seems to have been quite happy, apart from the fact that the patient was again frigid.

Case 20, M.L. This patient met her husband when she was twenty. He was four years older than herself and apparently stable. They married after a courtship of two years. Following marriage intercourse was infrequent and unsatisfactory to the patient, but, apart from that, the marriage seems to have been reasonably happy.

Case 12. M.C. This patient met her husband when she seventeen. He was eight years older than herself and more emotionally attached to the patient than she to him. The patient's mother, to whom she was very attached, did not like the husband, as he was frequently out of work and it seems that he was not a particularly stable personality. They had pre-marital intercourse after they had known each other for some years and the patient eventually became pregnant. Although the pregnancy was terminated, they became engaged at that time and married three months later. Following that, the husband came to work in the pub which was owned by the patient's mother. During the years which followed, a great deal of tension was created in the patient who was torn between her mother and her husband who were never able to get on together. Six years after their marriage, during the time her husband was away in the services, the patient had an affair with a married man which resulted in intercourse on two or three occasions and about which she felt extremely guilty.

B. ATTITUDE TO MOTHERHOOD (including (a) and (b)).

Case 24. N.C. This patient apparently wanted to have children and after the birth of her first child was extremely happy. As, in fact, prior to her second pregnancy she was told there was a possibility of having a Caesarian section, she was anxious and fearful about the delivery of her second child. She was not eager to have the second child, as her husband, at that time, was having an affair with another woman with whom they lived.

Case 17..R.E.W. This patient was anxious to have children and first conceived on her honeymoon. Shortly afterwards she had a spontaneous miscarriage and was much upset by this. Another child was planned for and it was a great shock when she again had a miscarriage. It was with considerable pleasure therefore that she carried the next child to full term, but it was following the birth of this child that she broke down.

Case 23. W.S. In spite of her frigidity, this patient was always anxious to have children and in the pregnancy in question this was particularly so, as her marriage at that time was not satisfactory and her husband was constantly out organising things at a men's club. She regarded the pregnancy in this case therefore as a compensation for his absence. It is to be noted that during the pregnancy, however, she had frequent attacks of migraine.

Case 22. A.S. This patient's first pregnancy occurred before marriage and the baby died shortly after the birth. It is doubtful whether the patient wanted the child that caused the present breakdown, for as will be seen later, living conditions were so difficult that it was obviously going to make things extremely hard for her.

Case 18. R.H. This patient wanted children and had an abnormal desire to have only male children. Each pregnancy was undertaken therefore with the idea of having a male child and the birth of each girl in turn became an ever increasing disappointment to the patient, particularly as she conceived only after long arguments with her husband who did not want any children at all. Although she was determined to have this last child in order to try and get a boy, it was probably carried through only with grave misgivings as she could count on little support from her husband.

Case 25. F.H. This patient certainly had an abnormal attitude to childbirth. She did, in fact, have premarital intercourse with her husband and another man but the idea of pregnancy in relation to this never seems to have occurred to her. At the time of her marriage, however, she insisted upon her husband undertaking that they should have no children. She did, none the less, become pregnant after marriage on a number of occasions and each time developed neurotic symptoms until she had a miscarriage. The frequent miscarriages were related to an Rh. incompatibility between her husband and herself. It is interesting to note that this patient was better in health during the five months her husband was away in the services, than at almost any other time in her adult life. She regarded pregnancy as one of women's misfortunes and disliked the idea of the distortion of her body by the pregnancy, and it seems that the final pregnancy, which went almost to term, was only allowed to do so by the patient as a result of two factors. The first was considerable criticism from her mother-in-law for not having had children, and the second a sudden fear on her part that she was reaching the end of the childbearing period with resulting doubt as to whether her attitude had been right previously. When she found out that the child was probably likely to be stillborn at the sixth month of pregnancy, her only reaction was one of satisfaction and anxiety to get rid of the child, feeling now that honour had been satisfied and that she had done her best. This patient was also terrified of the idea of labour and could not envisage herself being able to manage children.

Case 16. E.L. Although this patient was not fundamentally opposed to childbirth in general, she was so in the particular situation in which she found herself. She considered, because her marriage had been in a Protestant Church, that it was not a marriage at all and felt that she had no right to bear children and her feeling of guilt was accentuated by the child being christened into the Protestant Church.

Case 19. V.P. In this instance the patient does not seem to have rejected the idea of childbirth in general, but after a somewhat difficult time in giving birth to her first and illegitimate child, there was considerable fear of the process of labour and in addition to that, she did not want her second child immediately after her marriage, particularly as they had no-where to live.

Case 15. E.D. This patient did want children and had no particular fears about bearing them. Her attitude, however, undoubtedly changed towards childbirth when her marital situation became so bad and her relationship with her husband so extremely unsatisfactory, and she began to feel, in these circumstances, that she could not face bringing up further children.

Case 14. M.B. As has already been indicated in the previous section, this patient did not want the child which caused the present breakdown, because she felt that she would be unable to manage more than two children. She was therefore much upset by finding herself pregnant once more.

Case 21. A.K. There is little evidence to show that this case had any particular aversion to childbirth in general, but it is possible to postulate that owing to her husband's infidelity the year previous to the present pregnancy, that she may have faced this one with some misgivings, particularly as he was not anxious, because of financial reasons, for her to become pregnant again.

Case 20. M.L. This patient had always been rather prudish in sexual matters and had little real sexual knowledge. She was terrified at the prospect of childbirth when she found herself pregnant shortly after marriage, and her fear increased when neighbours regaled her with many frightening tales. She had little notion of the actual process of childbirth and no-one bothered to enlighten her about this. She was determined to have only male children and even the fact that she finally bore a son had no effect in allaying her fears and dislike of the process of childbirth, so that she waited nine years before she became pregnant again.

Case 12. M.C. This patient never wanted to have children and felt herself incapable of any motherly feelings towards them. During her marriage she procured a number of abortions on herself, in her attempt not to bear children. Even after having had one child, she had to depend on somebody else for the first eighteen months of its life, to bring it up because of her own inadequacy in doing so. Her attitude to childbirth never changed throughout her married life, and the pregnancy which produced the present breakdown was not wanted and it was carried on in a spirit of rebellion towards her mother, who had advised her to once again terminate the pregnancy. In this case there was no particular fear of labour itself, but rather of the management of the child altogether.

C. DELIVERY (including (a) to (e)).

Case 24. N.C. This patient developed a toxæmia of pregnancy and the labour was induced ten days before term. Delivery itself, however, was quite normal and straightforward.

Case 17. R.E.W. In this instance the patient remained well throughout the pregnancy but during labour there were several events which upset her. She was placed in a bed near a dripping tap. When she requested that it should be turned off this was refused. Later on, the anaesthetic machine broke down. Her labour lasted twenty-seven hours and she had a severe tear requiring several stitches. The handling from the nurses following her delivery was rather callous. On one occasion she was given castor oil and left to wait an hour for a bedpan. Following her return home, she found that looking after the baby was very difficult and felt unable to turn to her mother for help as her attitude was very unsympathetic.

Case 18. R.H. This patient rather regarded a satisfactory labour as an end in itself. Her first child was born after a difficult forceps delivery and the child was jaundiced, so that she was not allowed to see it for the first twenty-four hours and was convinced therefore that it was dead or deformed. Before the birth of her second baby she practised relaxing exercises and the delivery went off very smoothly and gave her a great deal of satisfaction. The third and last pregnancy was, in fact, quite satisfactory, but she regarded the labour as rather a failure on her part as she was given an anaesthetic which she considered should have been unnecessary.

Case 25. F.H. At the fourth month of pregnancy this patient had a haemorrhage and at the sixth month could feel no movements and was informed that possibly the child was dead. This, however, did not upset her in view of her attitude towards childbirth. She went into labour at the seventh month of pregnancy and the child was stillborn after a labour of seven hours.

Case 16. E.L. This patient's first child died of gastro-enteritis ten weeks after delivery. The patient developed a T.B. pleural effusion and was hospitalised for some months after the birth of the child. The birth of her second baby was a normal straightforward labour and delivery, but the baby had stomach troubles and the patient thought that it might be developing gastro-enteritis which worried her considerably. However, it was treated with Eumydrin and recovered satisfactorily.

Case 19. V.P. This patient's first pregnancy was an illegitimate one. She had high blood pressure towards the end of the pregnancy and was already in labour when she was taken into hospital. She was extremely tense and anxious and feared the child might be delivered in the ambulance. Apart from that, however, her labour was quite normal. She was married by the time she became pregnant again and prior to this delivery she was afraid that she might be left unattended while having the baby and was anxious about this in relation to her first experience of childbirth. There were students present at her labour and also later when she was being stitched for a tear, which she disliked very much, particularly as she was rather prudish. Other than that her labour seems to have been quite normal.

Case 15. E.D. The patient's first three children were born after quite straightforward deliveries. She became pregnant again a year after the birth of the third child and, because of the unsatisfactory marital situation, she procured a miscarriage on herself at three and a half months. She had a

severe haemorrhage and was taken into hospital for a D & C. She felt extremely guilty about all this and it was because of this guilt that when she found she was pregnant a year later, she determined to continue with the pregnancy. Her labour and delivery were quite normal but by the time she returned home, her illness had already started and she was quite unable to cope with things in the house.

Case 14. M.B. This patient's first two deliveries were perfectly normal but the third one, which produced the present illness, was a breech delivery. During the puerperium she had vomiting and diarrhoea and a slight rise in temperature for two days. Immediately after her return home she found it difficult to resume her responsibilities again and was easily tired.

Case 21. A.K. This patient's first pregnancy and delivery were quite normal. In the second pregnancy her labour was prolonged but otherwise normal. A fortnight after delivery, however, she had 'flu' and it was then that her illness seems to have first showed itself, although at this time the depression did not last.

Case 20. M.L. This patient's first delivery, following which she had a breakdown, was an instrumental one, but otherwise there was nothing abnormal about it. Her second delivery, which was without instruments, seems to have been quite normal and straightforward.

D. FEEDING DIFFICULTIES. (including (a) and (b).)

Case 24. N.C. This patient breast fed her baby and only discontinued because she was admitted to hospital when her illness started.

Case 27. R.E.W. This patient breast fed her baby but was ill by the time she returned home and found the general management of the child, not only the feeding, a difficult task.

Case 23. W.S. This patient breast fed her child quite satisfactorily until two months after her delivery, when her illness started. She lost interest in the child when it began to lose weight and had to have supplementary feeding. She seems to have had no objection to breast feeding the child, however.

Case 18. R.H. This patient made a fetish about breast feeding in all her pregnancies, although she found the management of the child in each case a difficult matter. The strain of breast feeding was marked after the birth of her second child. Following the birth of the third child, she found the management even more difficult than previously, but felt it again her duty to continue breast feeding but had constant anxiety for fear she would lose her milk. This fear persisted throughout her illness and she repeatedly became convinced the child was not having enough whenever it failed to gain sufficient weight.

Case 16. E.L. Both the babies of this patient had had feeding difficulties, although the patient did not have much to do with the handling of the first one, as she herself was taken to a sanatorium because she had a T.B. pleural effusion. After the birth of the second child she was worried a great deal because it was vomiting and not feeding properly, but once again, because she had developed a T.B. pleural effusion, she did not continue with breast feeding.

Case 19. V.P. This patient made rather an issue of breast feeding and insisted upon feeding her second child for nine and a half months, but found this an ever increasing strain as her illness became more and more marked.

Case 15. E.D. This patient successfully fed her first three children for an adequate length of time. Following the birth of her fourth child she soon became more and more ill and found breast feeding an additional strain and only continued it for one month.

Case 21. A.K. After the birth of the patient's second child she at first breast fed but about a fortnight after the birth she developed 'flu', lost her appetite and had a slight degree of depression at that time. Her milk left her and the baby had to be weaned, although the patient recovered from that episode of depression temporarily.

Case 13. M.A. Feeding difficulties did not seem to play a part in this case as the patient usually went into a depressive illness either in pregnancy or immediately after delivery, so that she never breast fed.

Case 20. M.L. After the birth of the patient's first child, the baby was cross and difficult with feeding and the patient worried a good deal about that. She did continue to breast feed until the child was nine months old, however.

Case 12. M.C. After the birth of the first child this patient breast fed for three months, but lost her milk at the end of that time and the child was weaned. The patient was pleased about this, as feeding interfered with the hours of the pub and also because she felt incapable of bringing up the child in any case. After the birth of her second child she was unable to breast feed because of an inverted nipple and was upset by her inability to do so.

E. SOCIAL FACTORS. (including (a) to (g).)

Case 24. N.C. In this particular case there did not seem to be any marked social factors operative. Financially they were not badly off but the husband had not been earning for some time because of his neurotic illness and therefore the patient had to support the family from her own private means. There is no evidence that this upset her particularly.

Case 17. R.E.W. In this case there were a variety of social factors which may have played a part. Following the marriage, the patient lived with her own people where the home was overcrowded and where her mother did not have a particularly sympathetic attitude towards her.

Case 22. A.S. Owing to the instability of the patient's husband there was never a particularly stable home life for this patient, owing to his financial losses and unsuccessful business projects. After the death of the first baby the patient's husband deserted from the Army and during that time she had to support him. Shortly after the birth of the second child they moved into a flat in which they now live. Gradually as the child got to the age of crawling, the neighbours became more and more troublesome, banging on the ceiling at the slightest noise, so that the patient felt compelled to take the child out every afternoon whatever the weather in order to avoid trouble. Thus the patient found it very difficult to cope with her housework. This constant restriction of the child seems to have resulted in the child getting night terrors and being referred to a Child Guidance Clinic. It was in these circumstances that she became pregnant for the third time and during this time the trouble with the neighbours got worse, particularly after her younger child had thrown a brick at the neighbours' children. The neighbours apparently interfered in her home life and accused the family of having black market coal, etc. This patient's mother-in-law had never accepted her, owing to the premarital pregnancy. Although they did not actually live with the mother-in-law the relationship between them was very difficult.

Case 16. E.L. Social factors were marked here. The patient resented very much having to live with her husband's parents, where she had to do the cooking for the whole family in addition to going out to work herself. She never felt free to go to her own parents as there was considerable friction between the parents and parents-in-law. The accommodation which they were given in the home of her in-laws was not very satisfactory. Financially they were never particularly secure as the husband had always borrowed money from his own mother when in need and consequently frequently spent more than he had, and this perpetual state of indebtedness upset the patient very much.

Case 19. V.P. After the patient's first illegitimate pregnancy she had a very difficult life, trying to find domestic jobs to support herself and the baby, and up until the time of her marriage her life was extremely trying. Having made a marriage for security, they started by living in digs, which her husband had had prior to marriage, but the landlady refused to keep them on when she knew the patient was pregnant. The husband therefore got a job, as a Church caretaker, which had a flat attached to the job. This proved to be a very unsatisfactory arrangement from the patient's point of view as she was expected to do all sorts of jobs such as washing up after functions at the Church Hall, making tea, etc., and her husband was very unreliable in his part of the work and would forget to put water in the font for christenings, etc. Shortly after taking on these extra strains the elder child was brought back from a nursery where she had been living, and this constituted an additional burden. Financially they were poorly off and were paid quite inadequately for the amount of work they did, often working until 11 o'clock at night. The patient had little time for running her own small flat and in any case there was an excessive amount of noise when the meetings were in progress in the hall beneath them. All this disturbed her greatly.

Case 15. E.D. The irresponsibility of the husband in this case made for a number of social problems. The steadily increasing size of their family with no attempt to curtail it; the inadequate accommodation with no proper water supply and no facilities for bathing the children, etc., and little money owing to the husband's drinking habits, constituted a major problem for this patient.

Case 21. A.K. In this case the husband was against further pregnancy because of financial difficulties. In addition they lived in a flat which was inadequate in size.

Case 20. M.L. At the time of this patient's first pregnancy, the financial position was very insecure, as she and her husband had not been married long. For this reason she did not want to become pregnant then and worried a good deal about her husband's financial state following the birth of the child.

Case 12. M.C. The social situation which was operative in this case and appears to have played a major part in the onset of this patient's illness, was the difficult atmosphere in the pub in which they lived. There were constant quarrels between the mother and stepfather or between the mother and the patient's husband. The patient and her husband felt neither servants nor masters in their job and the constant friction caused the patient a good deal of worry and anxiety. The patient's husband started drinking too much and the patient was worried because there was no room for her elder daughter to play and also she did not like her to witness the scenes between the mother and the stepfather. Any decisions that the patient or her husband made in relation to the work were always countermanded by the mother. During the patient's pregnancy, her husband managed to get a flat, but they kept this a secret from the mother whom they thought might object. The patient felt a good deal of guilt in relation to this and was very ambivalent in her attitude to moving, having lived with her mother in the pub all her life. She felt that she was being unfair to her mother in not having told her about the move, which occurred as soon as the patient came out of the nursing home after having her baby. The long working hours in the pub, even when they were not living on the spot, resulted in her seeing very little of her husband.

The findings related to the various headings dealt with under Adverse Life Situations have now been studied in relation to each individual case. Table 11b shows the sum total of these findings in all the multiparae. More detailed and tabulated information in relation to each patient may be obtained from the large chart on Page 137a.

Table 11(b)

<u>Social Factors</u>	<u>Marriage</u>	<u>Sexual or other mal-adjustment</u>	<u>Attitude to Motherhood</u>	<u>Child unwanted</u>	<u>Delivery</u>	<u>Incon-sider-ate nursing</u>	<u>Feeding Difficulties</u>
84.57%)	8. (57%)	11. (79%)	6. (50%)	11. (75%)	5. (36%)	1. (7%)	3. (21%)

From Table 11 it will be noted that the most important factor in the group of multiparae, would seem to be sexual or other maladjustments in the marriage. Social factors were present in a relatively large number of cases and instability of the husband appeared to be an equally important factor. Fears related to the responsibility of managing children was the next important group, while fear of labour and feeding difficulties appeared less often, and in only one case was there evidence of inconsiderate nursing.

Now that individual difficulties in both groups, (multiparae and primiparae), have been considered, an attempt will be made to co-ordinate the findings.

The table overleaf, Table 12, will show the factors which were present in the total number of cases studied.

<u>Social Factors</u>	<u>Marriage</u> <u>Unstable Husband</u>	<u>Sexual or other mal-adjustment</u>	<u>Attitude to Motherhood</u> <u>Fear of responsibility of managing children</u>	<u>Child un-wanted</u>	<u>Delivery</u> <u>Fear of Labour</u> <u>Inconsiderate nursing</u>	<u>Feeding Difficulties</u>	
10. (40%)	14. (56%)	18. (72%)	10. (40%)	16. (64%)	8. (32%)	7. (28%)	10. (40%)

From this table it would appear that sexual or other maladjustments in the marriage are present in an extremely high proportion of these cases, and seem to play a major role in the production of mental illness in relation to childbirth. By comparison with the figures shown in the individual tables for multiparae and primiparae, it will be seen that, the multiparae contribute the largest number of cases. The fact that the child was unwanted in an almost equally high proportion of cases, fits in with the first observation. In this group, the child was most frequently unwanted in the multiparae. Instability in the husband was relatively frequent and was present with equal frequency in both multiparae and primiparae.

Social difficulties of various types, feeding difficulties and fear of the responsibility of managing children, seem to occur in the same number of cases, and although not as important in the production of mental illness, at this time, as disturbances in the marital situation, they seem to play some part. Within these three groups, the multiparae contribute almost exclusively to the social factors, while almost the reverse is so in the primiparae. Both groups contribute almost equally to the figures shown, in relation to the fear of responsibility of managing children, with the multiparae showing the slightly higher figure.

Inconsiderate nursing and fear of labour appear in an almost equal number of cases, the former being markedly more in evidence in the primiparae.

Although these trends are of interest, they cannot be considered as having statistical significance owing to the small number of cases.

Previous Mental Illnesses Related to Childbirth.

Cruickshank in 1940 discussed previous mental illnesses in his group of eighty-four cases of psychosis occurring during pregnancy or the puerperium. It is to be noted that he gave the total as eighty-four, but on closer examination of these figures it was seen that the totals were, in fact, always eight-two. It is therefore difficult to work out any percentage from his figures because of this uncertainty as to what exactly was his total number of cases. At any rate, he divided his cases into three groups, toxic-exhaustive, manic-depressive and schizophrenic. In the toxic exhaustive group of thirty-two patients he stated that seven had had previous attacks, five of whom were multiparae in whom there was a previous illness associated with the first pregnancy. In the manic-depressive group of twenty-eight, nine had had previous attacks, four of these being multiparae in whom there had been a previous illness associated with the first pregnancy. One of these four, as well as five primiparae, had had an illness preceding and unrelated to the first pregnancy and in this group one particular patient (para 8) had eight attacks of post-partum depression lasting from one to two months and had not had an attack unrelated to pregnancy. In the schizophrenic group of twenty-two patients, seven had had previous attacks, four of these were multiparae in whom there was an illness associated with the first pregnancy. It is a pity that because of his failure to indicate how many cases were primiparae, and how many multiparae, it is impossible to say how many

multiparae there were without previous breakdowns. He sub-divided the three groups into cases whose first illness preceded the first pregnancy, secondly cases whose first illness was associated with the first pregnancy, and thirdly cases whose first illness was associated with subsequent pregnancies. If one works out the figures he gave, it showed that 13% of all cases had their first illness preceding the first pregnancy, while approximately 59% had their first illness associated with the first pregnancy, and 28% had their first illness associated with subsequent pregnancies. From these figures he drew the following conclusions. Firstly that these three groups might indicate varying degrees of vulnerability in that the first group gave way before pregnancy, the second at the first pregnancy, and the third not until a subsequent pregnancy; or secondly this might indicate that the disorganising forces at work varied in intensity from person to person and from time to time in the same person. In support of his latter conclusion he noted that in two cases both para 6, psychoses followed the first and sixth confinements with four intervening, normal, uncomplicated pregnancies in each case.

In the present group of twenty-five cases, working along the same lines as Cruickshank, it was noted that 24% had their first illness preceding their first pregnancy, 68% had their illness associated with their first pregnancy, and 8% had their first illness associated with a subsequent

pregnancy.

Cruickshank in 1940 also went on to give figures in more detail regarding the previous breakdowns in his group of cases. He said that thirteen of the multiparae in his group had previous attacks of mental illness from which they recovered. In every case at least one previous attack had been associated with a previous confinement and in eleven cases the only previous attack was related to pregnancy, indicating, he felt, that pregnancy was the only combination of physical and psychogenic forces, to which they had been subjected which was sufficient to precipitate a psychosis and that it did tend to recur.

In the present group of twenty-five cases, fourteen in all were multiparae and of these fourteen, eleven had had previous attacks from which they had recovered. In all but two of these eleven cases, at least one previous attack was associated with a previous pregnancy and in seven the only previous attack was related to pregnancy.

Cruickshank also stated that twenty-seven of his multiparae had had previous normal confinements and he considered that it was of interest that one pregnancy and not another, should be complicated by psychosis. In five cases he could find no significant change in physical or psychological factors other than the already present responsibility of motherhood. Eight cases were found to have

definite toxic or exhaustive complications, not reported with previous pregnancies, and in fourteen cases there were severe constitutional and psychogenic factors.

In the present series of twenty five cases, fourteen of whom were multiparae, five had had previous normal confinements, and in the following study it is hoped to show more exactly the nature of the difference between normal and abnormal confinements.

In addition to these findings and suggestions made by Cruickshank, McGeorge in 1938 recorded, in some detail, one particular case which he suggested was proof of the significance of precipitating factors. This patient had a breakdown in her first pregnancy when she was under particular domestic strains living with an extremely critical mother-in-law. This situation was rectified and she shortly became pregnant again and in the second pregnancy had no breakdown.

In addition to this case McGeorge also quoted one case as having had eight successive pregnancies, each one associated with an attack on mania. He cited another case as having had one manic, one confusional and one paranoid illness, occurring in two consecutive pregnancies and one miscarriage. Although he quoted these cases, he added that on the whole successive puerperal breakdowns were the exception rather than the rule.

Wick in 1941 noted two cases with previous

puerperal breakdowns and in six cases the first attack was associated with pregnancy. Ordway and MacIntyre in 1942, out of a total of eighteen multiparae, could show only one as having had a history of previous puerperal psychosis, although the family history was negative in twelve of these. Schmidt, on the other hand, in 1943 contradicted McGeorge by saying that these breakdowns occasionally recurred in subsequent pregnancies, and Jacobs in the same year thought that there was a tendency to recurrence particularly in the manic-depressive group of cases. In view of the suggestions made by these writers it was thought that it would be of interest in the multiparae in this series to make a study of the life situations from the point of view of deciding whether, with changes in these life situations, there was any difference in the likelihood of breakdown in relation to pregnancy. For this purpose the total number of fourteen multiparae was divided in the following way. (1) Those multiparae who had never had a previous puerperal breakdown. These total five of the whole number of cases.

(2) Those multiparae with previous puerperal breakdowns and previous normal pregnancies. These total three of the whole number of cases.

(3) Those multiparae who had previous puerperal breakdowns in all previous pregnancies. These total six of the whole number of cases.

These three groups will now be considered in more detail from the point of view of indicating possible changed in life situations.

1. Multiparae without previous puerperal breakdown.

- (a) Case 12. M.C. (The life situation in this case had altered vastly since her first pregnancy in which she did not break down. The atmosphere in the pub where she lived had become very strained with friction between her husband and mother and stepfather. She herself was dominated by her mother, was watching her husband drinking ever increasing amounts, had no place for her only child to play and in this impasse her husband decided to take a flat, which was done secretly without her mother knowing. This in itself caused great conflict in the patient who had lived all her life under her mother's roof. Added to all this was an unwanted child whom she had, only because of her mother's advice to terminate the pregnancy again.
- (b) Case 21. A.K. In this case there seems to have been several additional factors operative since she had had a child without breaking down. Perhaps the most important of these was the fact that the year before the present pregnancy her husband fell in love with her best friend, causing her much unhappiness and insecurity in her marital situation and leading to a miscarriage which she said was spontaneous. Added to this the circumstances in which she now lived were most unsatisfactory with considerable overcrowding. Her pregnancy was unwanted not only by herself, but this time by her husband, whose financial circumstances were inadequate.
- (c) Case 15. E.D. In this case again, there were many circumstances present which had not been operative before in her three previous pregnancies. Her marital situation had deteriorated with each successive pregnancy. Her husband drank constantly, the money was scarce and home conditions were overcrowded and unsatisfactory. Her husband accused her of being unfaithful, denied paternity of the children and persisted in steadily increasing mental cruelty. This primarily resulted in the patient procuring a self-induced abortion about which

she had great guilt. In spite of denying paternity of the children the husband's demands for intercourse did not lessen and the patient was in a constant state of fear regarding further pregnancies, and it was in this state of mind that she again conceived.

- (d) Case 24. N.C. The change in the marital situation in this case was the vital factor which had altered since her first breakdown. Her husband was unfaithful to her, but at the same time incapable of reaching any decision between herself and the other woman. In addition there was the added factor of a toxæmia of pregnancy which was not present the first time.
- (e) Case 20. M.L. This patient broke down on her first, but not her second pregnancy. There were various factors operative for the first time which were not present in the second pregnancy. Most important of these was the fact that the patient's fears regarding childbirth had been dispelled by the actual knowledge of the process acquired in the first pregnancy. In addition the first child was not wanted as it was too soon after her marriage and her husband was financially insecure. The first was a very difficult baby, both in relation to its feeding and its constant crying, whereas the second child was relatively simple to rear. This latter is of interest from the point of view that the patient's own insecurity and inexperience in the first case may well have been responsible for the first child being so difficult, the whole thing becoming a vicious circle.

2. Multiparae with previous puerperal breakdowns and previous normal pregnancies.

- (a). Case 14. M.B. After the birth of her first child the patient was depressed for six months, but not to a degree requiring hospitalisation. After the birth of this child the air raids caused her much anxiety, the baby cried constantly and was very difficult to rear. The second child although not wanted was an easy baby to bring up, and the patient was relatively secure in her own ability to cope with two children. She felt certain, however, that three would be too many to manage and as a result was constantly afraid of further pregnancy, becoming ever more tense and anxious on every occasion of intercourse. It was in this state of mind that she conceived for the third time and was confirmed in her fears of future management by the first child being ill frequently during her third pregnancy.

- (b) Case 22. A.S. The first child died of spina bifida and the patient became depressed following its death. She was well after the birth of her second child, but when the child became ambulant they moved to a new flat where they had considerable difficulties with the neighbours regarding noise, resulting in over-restriction of the child who had to be taken to a Child Guidance Clinic. It was at this time that the patient started her third pregnancy and was depressed throughout its course subsequently becoming worse after delivery. It would seem that the constant troubles with the neighbours and the necessity therefore to restrict her child, who became even more disturbed as a result, were all cumulative factors which had not been operative during previous pregnancies.
- (c) Case 18. R.H. This patient broke down after her first pregnancy. In this instance several factors were operative. She had a difficult forceps delivery, the child was jaundiced and her husband was called up. Her second delivery was an easy one and there was no breakdown. Following that, however, her constant demands to have a son disturbed the marital situation as her husband had never wanted children and considered two, more than enough. Her insistence against her husband's wishes on further pregnancy, coupled with his threats that he would leave her, and the final blow of having a third girl after all her difficulties, seem to have been responsible for precipitating the breakdown in her third pregnancy. The fact that she was mildly depressed and anxious during the pregnancy, would appear to reflect her increasing insecurity.

3. Multiparae with previous puerperal breakdowns in all previous pregnancies.

- (a) Case 13. M.A. There is little evidence in this case that any adverse situation played a part in this patient's breakdowns. The fact that she had a breakdown following her first pregnancy, two subsequent breakdowns related to further pregnancies, and two more breakdowns unrelated to pregnancy seems to indicate that childbirth in itself acted as a precipitating factor, but that even without this she was liable to depressive illnesses. It is of interest that her sister had a similar series of breakdowns, although the latter perhaps had more definite precipitating factors in addition to childbirth. Their mother died in a mental hospital during a depressive illness, which also

points to the fact that an adverse heredity was the most important factor here.

- (b) Case 23. W.S. There appears to have been no difficult life situation prior to the first pregnancy in which she nevertheless broke down with a depressive illness. She had a second breakdown which was unrelated to childbirth, the only possible precipitating cause being slight, viz., the absence of her husband and the illness of her child. Between that and the second puerperal depression the marital situation became rather unsatisfactory and she again broke down following childbirth. The paucity of precipitating factors in her life apart from pregnancy itself seems to indicate that in this case as in that of her sister (M.A.13) heredity played a large part.
- (c) Case 16. E.L. In this case the basic reason for conflict remained unaltered between the patient's two pregnancies, in both of which she had a depressive illness. This conflict was a religious one in which she considered her marriage null and void as it was outside the Roman Catholic religion. Her feelings of guilt were further accentuated by the death of her first child and she was never completely well between the pregnancies. In addition to this factor, which persisted throughout, she had another reason for breaking down in the second pregnancy, in the illness and death of her father-in-law who had been the chief opposer of a Roman Catholic wedding. Her difficult living conditions in the home of her in-laws, and her husband's too close attachment to his mother, were both added factors which continued to operate from the outset of her married life. There was also a physical factor here in the development of T.B. pleural effusions after both deliveries.
- (d) Case 19. V.P. The first of this patient's pregnancies was an illegitimate one, causing her great anxiety, and although she did not break down until ten months after the birth it was directly related to the difficulties of finding a job to maintain the baby and herself, as she had no husband. In her second pregnancy, although this time she was married, her husband was not at all the secure and stable personality she had expected. In addition they had an extremely hard job with little pay, no free time and the patient constantly having to help the husband to do his work as well as manage the home. The return home of her illegitimate child added to her difficulties as she felt her to be a constant reminder of the past and therefore a danger to what present security she had.

- (e) Case 25. F.H. The pregnancies in this case never reached full-term owing to an Rh incompatibility with her husband. Her difficulties seem to have been based mainly in her own personality. She was a chronic neurotic of many years standing and had three breakdowns before marriage. The first seems to have been precipitated by the death of her father, the amputation of her boy friend's leg with consequent desire but inability to leave him, and a clandestine affair with her boss. Her second breakdown followed a year later and was still due to conflict over the same matters. Her third breakdown occurred in relation to her fiance insisting upon marriage, and her four subsequent breakdowns occurred every time she conceived, although the last time she remained well until the delivery of a seven months still-born child, and then broke down. In her case the consistent wish to avoid marriage and childbirth, with breakdowns occurring whenever these appeared imminent, seems to be the major factor and was situated in a deep-seated personality disturbance.
- (f) Case 17. R.E.W. This patient's illness seems to have been precipitated in her first pregnancy by inconsiderate nursing, with resultant fear of childbirth and, on her return home, little understanding or help from her mother. The second breakdown occurred at the outset of pregnancy before she has fully recovered from her first puerperal illness, and was determined by the fear of having to go through her previously alarming experiences of childbirth over again. The fact that she was anxious to have a child and was much upset by her previous miscarriages, adds strength to the argument that her terror of childbirth was largely responsible for her breakdowns.

Broadly speaking the study of these three groups would seem to show that in those multiparae without previous puerperal breakdowns, and in those who had had previous puerperal breakdowns and previous normal pregnancies, there does seem to be a reasonable amount of evidence to show that there were fairly significant changes in their life situations between normal and abnormal pregnancies.

In the third group, i.e., those multiparae with previous puerperal breakdowns in all previous pregnancies, who total six in number, there is relatively little evidence that there were changing adverse life situations, but rather that the difficulties lay in the personality or heredity of the individual which of course remain constant throughout; or in adverse life situations, which were persistent. In the following review of these six cases an attempt is made to show which of these three possibilities was mainly operative.

Case 13 M.A., and 23 W.S. Would appear to have been largely due to heredity factors.

Case 16. E.L. Appears to have been basically due to a fear rooted in conflicts, which were present at the outset of her marriage and therefore persisted through both pregnancies.

Case 19. V.P. Showed persistently difficult life situations, both of a different nature in each pregnancy and these were certainly super-imposed upon a basically unstable personality.

Case 25. E.H. Showed an unstable personality with particular difficulties related to childbirth, so that one would expect in fact, that this case would be liable to break down each time she became pregnant.

Case 17. R.E.W. Seems to have been largely due to inconsiderate handling in her first pregnancy with resultant fear of childbirth, so that on becoming pregnant a second time very soon after her first traumatic experience, she again broke down. In point of fact she was never well enough to be without treatment from the time of the first delivery onwards. Probably, therefore, the illness which occurred in the second pregnancy might be considered really as a continuation of the first.

Breakdowns Unrelated to Childbirth in
Multiparae.

Now that the changing factors in relation to abnormal and normal pregnancies have been considered, it is proposed to study these cases from the point of view of previous breakdowns not related to pregnancy, as has already been done with the group of primiparae.

Hinson, in 1942, stated that many patients have similar breakdowns preceding pregnancy and that in these breakdowns the strains that the patient is subjected to are of a similar intensity.

In the fourteen multiparae studied here, it was noted that seven had had breakdowns unrelated to childbirth. Of these seven, three had had their breakdowns prior to pregnancy and the remaining four had had them either following a puerperal breakdown or a normal pregnancy. In studying these three cases with breakdowns occurring before the puerperal breakdown, one notes that:-

Case 24. N.C. Appears to have broken down following the death of her mother and her father's remarriage.

Case 25 F.H. Had three breakdowns previously, the first two appear to have been related to the death of her father and to a boy friend having a leg amputated, the patient wanting to leave him but being unable to make the decision to do so, and at the same time having an affair with her employer. The third breakdown occurred at the time when her fiance insisted upon her making a decision regarding marriage.

Case 21. A.K. Had her previous breakdown at the time of her engagement, at which time she imagined that she had swallowed a tooth brush bristle.

To sum up it would appear that two out of those three cases had their previous breakdowns in relation to engagement or marriage.

In studying the four remaining cases who broke down after having had a puerperal illness, one notes that:-

Case 20. M.L. Had an involutional depression which was related to a difficult domestic situation with her son and daughter-in-law, occurring many years after per puerperal illness which was related to her first pregnancy. In addition she had had a subsequent normal pregnancy.

Case 13. M.A. Had two breakdowns of a depressive nature within three years of each other which followed a puerperal breakdown in her first pregnancy, this latter culminating in separation from her husband. In this case it has already been noted that heredity had played the largest part in her breakdowns.

Case 23. W.S. Had a depressive illness following a puerperal depression. The only possible factors which might have been operative at this time in her life were the illness of her child and the fact that her husband was away, although heredity would appear to have been the most potent factor here as it was in the case of her sister (M.A.). It is of interest to note that this case broke down again, as did her sister, in her only subsequent pregnancy.

Case 12. M.C. Had a depressive illness of three months duration in the years following her first pregnancy. She did not break down in the first pregnancy, but the depressive illness subsequently appears to have been related to the fact that she was unfaithful to her husband during his absence in the Forces and was extremely guilty about it.

To sum up, therefore, the findings in these four cases: In one there appears to have been a difficult life situation occurring at the involutional period. In two there were difficult marital situations but there was an adverse heredity as well in both these cases, while in one the breakdown was again related to a disturbance in the marital situation. Therefore out of the total number of seven multiparae with breakdowns unrelated to pregnancy only two can be considered as having

broken down in relation to factors that were entirely remote from it, or marriage, etc.

The following table shows the total number of previous breakdowns in the 14 multiparae:-

TABLE 13.

No Breakdown	Breakdown outside Pregnancy and Puerperium	Previous Breakdown Related to Pregnancy & Puerperium.
1	7	9

In addition to this an attempt has been made to sum up the relative importance of heredity, personality structure and difficult life situations in each individual case. The following table shows the multiparae and their breakdowns whether puerperal or otherwise.

In cases where there was a breakdown not related to pregnancy directly the table also shows whether this was before or after the first pregnancy, whether normal or otherwise. Each case then, has the factors considered to be most important, marked alongside. Personality factors are shown as (P), Life Situations as (L.S.) and Heredity as (H).

TABLE 14.

	Multiparae without previous puerperal breakdowns	Multiparae with previous puerperal breakdowns and previous normal pregnancies.	Multiparae with previous puerperal breakdowns in all previous pregnancies.
Multiparae with breakdowns unrelated to pregnancy	Before N.C.(24)L.S. A.K.(21) " After M.C.(12) " M.L.(20) "&P.	-----	Before F.H. (25) P. After M.A. (13) H. W.S. (23) H & L.S
Multiparae without breakdowns unrelated to pregnancy	E.D.(15)L.S.	M.B.(14)H&P. A.S.(22)LS & P. R.H.(18)LS & P.	E.L.(16)L.S. V.P.(19)L.S. & P. R.E.W.(17) L.S.

From Table 14 it will be seen that once again adverse life situations were present with greater frequency than personality defects or poor heredity, in these fourteen multiparae. In six of the cases personality difficulties played a part, and this was in some instances associated with an adverse life situation. Heredity factors were least common. If this table is compared with Table 11 which shows similar factors in the primiparae, it will be seen that, adverse life situations appear more frequently in the group of multiparae, while heredity is of equal importance in both groups and personality difficulties are almost equally common, although present with slightly greater frequency in the primiparae.

Drunkenness or psychopathy.	Early Environment.	Personality features in adult life.														Hus- band	Marriage		Previous Mental Illness	Attitudes to Childbirth & Difficulties in Labour.										Illness.	Symptoms in pregnancy.													
	Maladjustment of parental marriage or other abnormal parental situation.	Neurotic symptoms shown by patients in childhood.	Attitude to periods or sex in adolescence faulty	Work record unstable or inadequate	Mood swings	Poor mixer or few friends.	Over-dependence on parents. Mother M. Father F.	Obsessional traits. Houseproud, high standards, etc.	Socially or otherwise ambitious.	Hypochondriacal or easily tired.	Desire to be a boy or have male children persisting into adult life.	Over-anxious.	Insecure.	Conscious rejection of motherhood	Nervous breakdown.	Unstable personality	Premarital sexual intercourse.	Marriage maladjusted due to sexual causes.	Marriage maladjusted due to other causes.	Husband. Unfaithful	Patient, unfaithful	Pregnancy before marriage.	Parity	Total number of breakdowns following childbirth.	Total number of breakdowns outside childbirth	Fear of Labour	Fear of managing children.	Inconsiderate nursing.	Tears	Bad anaesthesia	Instruments	Prolonged labour or abnormal presentation.	Child unwanted.	Child overdue or premature.	Feeding difficulties.	Social factors.	Reaction type.	Time of onset	Rejection of child during illness.	Rejection of husband.	Life situation evident in illness.	Symptoms present in pregnancy.	Excessive vomiting in pregnancy.	
-	X	X	X	-	X	-	-	-	X	-	-	-	-	-	X	-	X	-	X	-	-	-	2	1	1	X	-	-	-	-	-	-	X	X	-	-	Sch Aff	1m	X	X	X	-	-	
X	-	X	X	-	X	X	-	-	-	-	-	X	X	-	-	-	-	-	-	-	-	-	2	2	0	X	X	X	X	X	-	X	-	-	-	X	Dep	"	X	X	X	-	-	
-	X	X	X	-	X	X	-	-	-	-	-	X	-	-	-	X	-	X	X	-	-	-	2	2	1	-	-	-	-	-	-	-	-	-	-	-	Mix Aff	2M	X	-	-	-	-	
X	X	X	X	X	X	X	X M	X	X	-	-	-	-	-	X	-	X	-	X	-	-	X	3	2	0	-	X	-	-	-	-	-	X	-	-	-	X	Para	1m	-	X	X	X	-
X	X	X	-	-	X	-	X F	X	-	X	X	X	X	-	-	X	X	-	X	-	-	-	3	2	0	-	-	-	-	-	X	-	-	-	-	-	Dep	1M	X	-	X	-	-	
X	-	X	X	X	-	-	X M	-	-	X	X	X	X	X	-	-	X	X	-	-	-	-	4	4	3	X	X	-	-	-	-	-	X	-	-	-	-	Anx	2W	X	-	X	X	-
-	X	X	-	X	-	-	X M	X	-	X	-	X	X	-	-	X	X	X	X	-	-	-	2	2	0	-	-	-	-	-	-	-	X	-	-	-	X	Dep	2D	X	X	X	X	X
X	X	X	X	X	X	-	-	X	X	-	-	X	X	-	-	X	X	X	X	-	-	X	2	2	0	X	-	-	X	-	-	-	-	X	-	-	X	Anx	3D	X	X	X	X	X
-	-	-	X	-	-	-	X M	X	-	-	-	X	-	-	-	X	X	-	X	-	-	X	4	1	0	-	-	-	-	-	-	-	X	-	-	-	X	Dep	10D	X	X	X	X	-
-	X	X	X	-	X	-	X F	X	-	-	-	X	X	-	-	-	-	-	X	-	-	-	3	2	0	-	X	-	-	-	-	-	X	X	-	-	-	Dep	6M	X	X	X	X	-
X	X	X	-	X	-	X	X M	X	-	-	-	X	-	-	-	-	-	-	-	X	-	-	2	1	1	-	-	-	-	-	-	X	X	-	X	X	Dep	3M	-	-	-	-	X	
-	X	-	X	-	X	X	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	3	2	2	-	-	-	-	-	-	-	-	-	-	-	Dep	2nd preg	-	-	-	-	X	
-	X	X	X	-	-	-	-	X	-	-	X	-	-	-	-	-	-	-	X	-	-	-	2	1	1	X	X	-	-	-	X	-	X	X	X	X	Dep	11M	X	-	-	-	-	
X	X	X	X	X	-	-	X M	X	X	X	-	-	X	X	-	X	X	-	-	X	X	2	1	1	-	X	-	-	-	-	-	-	X	-	X	X	Dep	4D	X	X	X	X	-	
X	X	-	-	-	-	X	X F	-	X	X	-	-	-	-	-	-	-	-	X	-	-	-	1	1	0	-	-	-	-	-	-	-	-	-	X	-	-	Sch	16D	X	X	X	-	-
-	X	X	X	-	-	-	X M	X	X	-	-	X	X	X	-	-	-	-	X	-	-	-	1	1	0	-	X	X	X	-	-	-	X	X	X	-	Dep	3W	X	-	X	X	-	
-	-	X	-	-	-	-	X F	X	X	-	-	X	-	X	-	X	X	-	X	-	-	1	1	0	X	X	X	-	-	-	-	X	X	X	-	-	Dep	5D	X	X	X	X	X	
X	Illegit	X	-	X	X	-	-	X	-	-	X	-	X	-	Not mar	X	-	-	-	-	X	1	1	1	-	-	-	X	-	-	-	X	-	-	-	-	Mix Aff	3D	-	X	-	-	-	
X	X	X	X	X	X	X	X F	X	-	X	-	X	X	X	-	-	-	-	X	X	-	-	1	1	2	X	X	-	X	-	-	-	X	-	X	-	-	Mix Aff	1W	X	X	X	X	-
-	X	-	-	-	-	-	X M	X	-	-	-	-	-	-	-	-	-	-	-	-	-	1	1	0	-	-	-	-	-	X	-	-	-	-	-	Sch	10D	X	X	-	-	-		
X	X	-	X	-	-	X	X M	-	-	-	-	X	X	-	X	-	-	-	-	-	-	1	1	0	-	X	X	-	-	-	-	X	-	-	-	-	Dep	3M	X	X	X	-	-	
-	-	X	-	-	-	X	X M	X	-	-	-	X	-	-	-	X	-	-	-	-	-	1	1	2	-	-	-	-	-	-	-	-	X	-	-	-	Sch	4D	-	-	-	X	-	
-	X	X	X	-	X	X	X F	X	-	-	X	-	X	-	-	-	-	X	X	X	-	-	1	1	0	X	-	X	X	-	-	-	X	X	-	X	X	Sch	9D	X	X	X	X	-
-	-	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	1	1	-	-	X	-	-	-	-	-	-	-	X	X	Sch	3D	X	-	X	-	-	
X	X	X	-	X	-	-	-	-	-	-	-	-	X	-	-	-	-	X	X	X	-	-	1	1	0	-	-	X	X	-	-	-	-	-	X	-	Anx	14D	X	X	X	-	-	

T A B L E 15

This table sums up the presence or absence of various factors, whether in the family history, personality, marital situation, difficulties in labour, social factors etc.

EVIDENCE IN FEATURES OF THE ILLNESS
OF ADVERSE LIFE SITUATIONS.

This section is added as a conclusion to the previous one, as it was thought that study of these cases, might show evidence of the actual adverse life situations in the content of thought during the illness itself.

Few writers report their case histories fully, so that it is extremely difficult to draw any conclusion from what has already been written on this subject. Hostility to husband or child had been noted by various authors, amongst them McGeorge in 1938, and Strecker and Ebaugh in 1926. Kraines in 1941 noted that particularly in those not desiring pregnancy there was indifference or hostility to the child during the illness. Apart from these points, the relationship of the content of the illness to any psychological conflicts which were present prior to labour, have not been recorded.

In the twenty five cases studied in this thesis, there appear to be a high proportion who showed such relationship between difficult life situations and content of thought in the illness related to childbirth. They were as follows:-

Case 24. N.C. This patient frequently asked during the course of her illness whether she were Mrs. or Miss C., and said that there were many Mrs. Cs. This was of interest in view of the relationship between her husband and the woman with whom they were living throughout the patient's pregnancy. Her anxiety about the other children and her fear that the baby might be born dead, were possibly both related to her dislike of becoming pregnant at that particular time.

Case 17. R.E.W. This case broke down in her second pregnancy and during her illness constantly seemed preoccupied with fears regarding a further labour. This is of interest in view of the bad time she had in the first and very recent labour when the nursing had been most inconsiderate. She blamed herself for not being able to do the work at home properly and apparently things had been very difficult for her there, even when she was well, the mother having little understanding of her difficulties and expecting her to do quite a lot to help.

Case 22. A.S. During her illness this patient expressed a considerable amount of hostility towards her husband and his inability to provide a stable social background. The insecurity created by her husband's lack of stability seems to have played quite a large part in the production of her illness. She also expressed guilt in relation to the death and developmental abnormality of her first child. As this particular child was illegitimate it is of interest that the guilt and anxiety associated with this particular pregnancy appeared again in relation to her later pregnancy.

Case 18. R.H. During her illness this patient expressed a sense of guilt about not being able to cope with things at home, for losing her temper with her other children, and overburdening her mother. She worried excessively over trivial matters, particularly in relation to money, and in view of the fact that she had little co-operation and help from her husband at home in managing the household affairs, it was not surprising that during her illness she was much preoccupied with basic questions of security. Her insistence on continuing to breast feed the baby in any circumstances is also of interest, as there is little doubt that when this child turned out to be another girl the patient rejected it strongly, and the over anxiety about breast feeding would appear to be a compensation for this rejection.

Case 25. F.H. During her illness this patient talked about her resentment of her feminine role in life, her dislike and fear of pregnancy and her fear of intercourse because of possibly becoming pregnant, and at the same time was worried constantly that her husband wanted to leave her. These preoccupations would appear to be closely related to the problems which had concerned the patient for the greater part of her married life to which she had never found any solution. Her reason for becoming pregnant with the child in question, was quite possibly at least partly related to the fact that she feared if she refused to have any children, her husband might well find somebody else who would.

Case 16. E.L. The religious conflicts in this case would seem to have played a large part in precipitating the present illness and were very evident in the thought content of the patient. Her ambivalence towards the child seems to have been rooted in the actual situation in her life which made her feel that in fact, because she had married outside the R.C. Church, she was not married at all and therefore had no right to have children. During her illness she would see her grandmother's face which seemed to be distorted and angry and she had the feeling that things were burning all round her. This is of interest in view of the fact that she married three months after the grandmother's death, and the grandmother had threatened to come back and haunt her should she ever lose her faith. She dwelt a great deal also in the venereal infection that she was supposed to have had as a child, and felt that it might have been responsible for the first baby's death and the second baby's stomach trouble.

Case 19. V.P. This patient during her second pregnancy dwelt much upon the incidents in her first delivery which had been rather unpleasant for her. She made a particular point of breast feeding her baby for nine and a half months and this insistence upon doing so, seems to have been related to her rejection of the child which she had not wanted particularly and certainly not so soon after marriage. She was constantly irritable and aggressive to her elder child and to her husband, and later felt that she had no feeling for either of them. Discussion with her brought out the point that suggested itself in the earlier part of her history, which was that she felt that her husband had not given her the security for which she had married him, and that the elder child being illegitimate, was a constant threat to the security which she had achieved.

Case 15. E.D. During her illness this patient became terrified of the idea of intercourse and preoccupied with the fear that she might become pregnant again. She was constantly worried throughout her illness about the difficulties of her marital situation and felt unable to return to them again, although she was constantly over-anxious at the beginning to return home and try to look after the children. The difficulties of her marital situation prior to her admission makes it not surprising that these were her preoccupations during illness.

Case 14. M.B. During her illness this patient became increasingly worried about not getting things done in the house and was unable to make up her mind about simple domestic matters such as what to have for meals, so that her normal routine became impossible for her to carry out. She kept repeating that the baby put her routine out of order and that she ought never to have married and had children. This is of

interest in view of the fact that since the birth of her second child she had greatly feared a further pregnancy and maintained that she could never manage to look after a third child.

Case 12. M.C. During her illness this patient worried before her admission to hospital, about not knowing what to do for the baby owing to her lack of motherliness. This was the feeling that she had always had and although she did not break down after the birth of her first child, she was acutely aware of this deficiency at that time. She repeatedly said that she could not look after the baby or the flat and it became increasingly clear during the time that she was in hospital, that she had entertained a great deal of guilt about moving into the new flat away from her mother for the first time in her life, and for keeping the move a secret. She considered that her husband would be better off if he left her and thought her depression a well-earned punishment for being such a hopeless person in the past. These features of her illness correspond rather closely to the difficulties in her life in which she was torn between mother and husband, and the fact that she felt very guilty about moving away from her mother without telling her; she felt also that she would be unable to cope with things in the flat, as all her life she had lived in the pub and done things under her mother's supervision until finally she had become utterly dependent upon her.

Case 8. J.W. During her illness this patient was very much preoccupied with anything to do with eyes. She stated that they were the key to her illness, had ideas about Yogi and associated Yogi with New Zealand, where she had an uncle who had had a head injury over the occipital lobes and she herself connected this with eyesight. She felt that she could damage people or their eyes if she looked at them. She thought that doctors were hypnotising her. She talked of using one's eyes positively and that, by so doing, one could pick up clues which the doctors were strewing about. She felt when she was told at the hospital that her baby's eye was damaged, that the doctors had hypnotised her while they told her, in order to lessen the shock. In addition she thought that her own eyesight was splitting up into rays. This is of interest in view of the fact that her child, who was a much wanted one, was born with a congenital eye defect. The other preoccupation in her illness seemed to be related to a situation in her life which was associated with her husband's higher intellectual ability, his attempts to improve his mind and her own struggles to try and compensate for it by excessive zeal on the domestic side of her marriage. As a result of her husband trying to improve her intellectually, she thought she had absorbed all his brain and that by losing a grip on

her own mind in illness, she was losing as well what he had given her. She felt that she could read her husband's thoughts and that she was being overwhelmed by the strength of his personality. Her talk of being at the centre point of a see-saw and of keeping a correct balance by giving and taking seems closely related to her own feelings towards her marriage. The diagrams which she drew before her admission showing brain and experience to be male, and art and intuition as female, and the relatively greater proportion of the former in relation to the latter in her diagrams, seems to have been indicative of her feeling of inadequacy and inferiority in relation to her husband.

Case 4. E.H. During her illness this patient worried constantly that minor mishaps would injure the child and went to endless trouble to make arrangements for its clothes, nursery etc. This over-anxiety in relation to the child is of interest in view of the fact that she was previously quite determined never to have any children and seems to have been over-compensating for her rejection of motherhood. She became markedly hypochondriacal, especially in relation to her reproductive organs during her illness and in fact stated that she thought the pregnancy had "messed up her inside" which is interesting in view of the fact that she was actually told by her mother that childbirth would do this. She was extremely upset by the constant treatments that were applied to her cervix following the severe laceration which she received during childbirth, and her anxiety would seem to have again been associated with her mother's early attitude. The fact that she worried that she might develop cancer as a result of these frequent treatments is also of interest as her mother died of cancer of the rectum and attributed this to childbirth. When she was first admitted to hospital she could talk of nothing but her physical health and the difficult time she had had in Venezuela.

Case 3. R.W. This patient also made meticulous plans for her child which she had not wanted and became excessively anxious because the baby lost weight. She was over-determined to breast feed which was again probably evidence of her rejection of the child. She blamed herself during her illness for neglecting her husband in the past and this is of interest in view of her extra-marital relations which were going on up to the time of her pregnancy.

Case 6. M.H. This patient's antagonism towards her husband and child, and the difficulty in persuading her to breast feed during her puerperal illness, seem to have borne out her attitude of rejection of childbirth which had been present all her life. Later

in her subsequent breakdowns unrelated to childbirth, her preoccupations were mainly to do with her inability to cope with her domestic life and it is of interest that during her younger days the mother had always discouraged her from doing anything to help in the home.

Case 2. I.M. This patient's feelings during her illness that her friends tried to avoid her, and her fear of offending shop assistants, seem to be merely an accentuation of her over-diffident and sensitive attitude which had been present all her life. Her self-reproach at having failed in her household duties and her inability to attend to the child were apparently merely an expression of the fears which she had had at the outset of pregnancy. During the recurrence of her illness after her operation for fibroids she worried about the baby's future and felt that she would never be able to cope with him and with his young friends and their parents. This, again, seemed to confirm her attitude prior to pregnancy that she would never be able to accept responsibility for the upbringing of a child. Her own doubts about ever having a baby, amounting almost to rejection of childbirth altogether, were evidence of her possible guilt for lack of affection towards him, and this guilt was greatly accentuated when visitors made a fuss of him.

Case 11. M.J.C. This patient did not want a child so soon after marriage and her anxiety about the child would appear to bear this out, particularly when she overheard the doctors saying, after the child's birth, that he was not breathing properly and was being given oxygen. The fact that during her illness she told her husband that they must have a nurse in as she was not confident to feed the baby might well be interpreted as an expression of her alarm at having to accept responsibility for the child when she herself was still so young. The feeling which she had had many years before in a recurring dream, that her fingers were swelling was also of interest, especially in relation to the fact that she later said, after she had been admitted to hospital, that she thought "she was a man again". The fact that she frequently stated that she had not yet had the baby, would seem to indicate again her unwillingness to have a child at that time. Much of her screaming and disturbed behaviour during her illness seem to be a re-enactment of the labour during which she had been over-active and over-anxious.

Case 7. S.R. In this case it is of interest that under intravenous sodium amytal the patient expressed ideas of guilt and self-reproach saying that she thought she was upsetting everybody and that her husband's people were "alright really" while she herself was "too pig-headed". In view of her difficulties with her in-laws and the unhappiness of the home situation with them, it is perhaps significant that she should talk about upsetting people there during her illness.

Case 1. A.V. During her illness, this patient worried about all the things that she would have to do in relation to coping with domestic duties and the baby, and the fact that she would now be unable to go out very much after having had seven years of comparative freedom in her married life. As her depression became increasingly marked she ruminated more and more about these things and said that she felt the baby had come between herself and her husband. She blamed herself for lack of interest in her husband and child, and wondered whether it was worth trying to make something of her marriage, which was of interest in view of her long standing marital difficulties.

To sum up these cases: eighteen out of the twenty-five showed evidence in their illness of the operation of various difficult life situations. Ten of these were multiparae and eight were primiparae. Although rejection of either husband or child during the course of the illness was evident in many of these eighteen cases, there were a further four cases who, although not showing evidence, in the illness, of the operation of difficult life situations, did show rejection of either husband or child.

POSSIBILITIES OF PREDICTION
AND PROPHYLAXIS.

From the point of view of possible prophylaxis of mental disorders occurring in relation to childbirth an early recognition of symptoms and the emergence of behaviour changes, would seem to be an important and essential point.

Various writers have discussed prodromal symptoms, among them Strecker and Ebaugh in 1926 who studied fifty cases. They thought that those women who broke down, following delivery, with manic-depressive reactions, showed depression, anxiety, and phobias in pregnancy; the phobias being mainly concerned with death, being alone, fear of being frightened by dogs, and additional fears which were unspecified. Their toxic-exhaustive group showed evidence of suspicion and quarrelsomeness during pregnancy, while the schizophrenics had depression and apprehension and were quick-tempered, nervous, exacting and constantly worrying.

In 1938 McGeorge quoted Jellett, and Johnstone as saying that in cases which subsequently developed puerperal mania, insomnia, irritability, disorientation, hallucinations, and furred tongue, there were common early signs which occurred immediately after delivery although McGeorge himself thought these were pre-cursors of confusional rather than manic illness.

Haworth, in 1939, noted irritability, restlessness, undue fatigue, emotional instability and insomnia as possible prodromal symptoms. Zilboorg, in 1928, mentioned the adoption of a masculine role by a woman between pregnancies, as being a possible warning sign of schizophrenic illness in subsequent pregnancies although Smalldon in 1940 did not confirm this point of view. Wick in 1941 could show only one case in his series in which symptoms were present during pregnancy while Chapman in 1943 thought that there were prodromal signs present in the depressive group of cases, but not in the manias, during pregnancy. Cohen also writing in 1943, felt that a fear of death during pregnancy was almost universal even in normal women. Many writers at one time or another have discussed the relationship of excessive vomiting during pregnancy to feelings of rejection towards the child although these writers are not, generally speaking, in agreement, some believing that there is a relationship and others not.

The twenty-five cases in this thesis have therefore been studied for evidence of symptoms which were already present during pregnancy and excessive vomiting, has in each case, been noted down as a separate factor. The cases will be quoted in more detail but broadly speaking, out of the fourteen multiparae, nine cases showed evidence of symptoms already during pregnancy and in four there was excessive vomiting during pregnancy. In only four

was there evidence of both excessive vomiting during pregnancy and early symptoms of psychiatric illness. In the primiparae, five of the total of eleven cases showed symptoms during pregnancy and only one had excessive vomiting and this one was not among the group who had symptoms during pregnancy. It would seem therefore from these figures that two conclusions may be drawn, firstly that as fourteen out of the total number of twenty-five cases showed symptoms in pregnancy, there should have been a reasonable chance of predicting a mental breakdown if difficulties in the lives of these patients could have been dealt with in the ante-natal period. Secondly, that excessive vomiting in pregnancy is by no means a reliable indicator of possible trouble to come after delivery, nor is there a close relationship between excessive vomiting and rejection of the child as reference to Table 15 will show that the child was an unwanted one in sixteen cases, while only five had excessive vomiting.

The following cases are discussed in slightly more detail to show the presence of the two factors already mentioned.

Case 22. A.S. As has already been stated, this patient was living in particularly difficult circumstances shortly after the birth of her second child. The necessity of restricting the child owing to the proximity of neighbours, showed itself in anxiety on the part of the patient and disturbance in the child. This latter forced her to take the child to a Child Guidance Clinic in 1947 and it was in that same year she became pregnant with the child who caused the present breakdown. It was noted

during that period that she became quite obviously depressed.

Case 18. R.H. This patient had an excessive amount of vomiting throughout pregnancy and became gradually more insecure until, after the fifth month, she began to worry increasingly over trivial matters particularly money, to a degree that she had never done before. There was evidence that in the last two years prior to her illness she had been more pessimistic than was her wont and during the pregnancy this became more marked and she developed excessive concern about her other two children.

Case 25. F.H. Every time this patient became pregnant she developed anxiety symptoms until, in each case she had a miscarriage. In her final pregnancy which resulted in her present illness, she became convinced that she was going to die, but otherwise showed no actual anxiety features until after the delivery.

Case 16. E.L. During both this patient's pregnancies she had excessive vomiting, was rather depressed, and in addition had various gastric symptoms prior to her delivery.

Case 19. V.P. This patient had excessive vomiting during the first six months of pregnancy, and from the third month of pregnancy onwards she started to become depressed. At seven months, following the move into their present flat, her depression deepened and she found it increasingly difficult to carry out her usual household and other duties.

Case 15. E.D. Although this patient was not grossly depressed during pregnancy, she found it increasingly difficult to get her housework done, and this was very unusual for her.

Case 14. M.B. After this patient became pregnant for the third time, she showed evidence of extreme worry as to how she was to manage three children, and during the time of her pregnancy she often felt unduly tired and found housework more trying than was usual for her when pregnant.

Case 21. A.K. During both pregnancies this patient showed excessive vomiting, although there was no evidence of the presence of psychiatric symptoms during her pregnancy.

Case 13. M.A. This patient started to become depressed a month after conception in the present pregnancy. There was no evidence of symptoms in her first pregnancy, but in her second, symptoms appeared at the third month.

Case 12. M.C. For two years prior to this patient's second pregnancy she was becoming increasingly indecisive and less cheerful than was customary for her. This became more marked following conception.

Case 4. E.H. During pregnancy this patient worried that minor mishaps would injure the child and made excessively zealous preparations for the child. She was emotionally rather unstable and wept easily for very little reason.

Case 3. R.W. This patient also made extremely meticulous plans for the child, seemed quite inflexible in all her arrangements, and unable to put first things first. Although she had always been fussy about her house this was carried to an extreme. She had more vomiting than was normal during her pregnancy.

Case 6. M.H. In this instance, although there was no evidence of depression or other psychiatric symptoms of a very definite nature during pregnancy, the strong conviction that she could not possibly bear a child, seems in itself to be evidence of disturbance even at that stage.

Case 10. B.E. This patient had her second attack of catatonia lasting a fortnight at the outset of her pregnancy.

Case 11. M.J.C. Throughout her pregnancy this patient had periods of depression which became more marked near to the time of her delivery when the date of delivery was somewhat overdue. When she finally did go into labour she was shivering, and apparently nervous on the way to hospital, and blamed herself for causing the ambulance men to make two journeys.

Various writers have discussed the prophylaxis of mental illness occurring in relation to childbirth and it has more particularly come under consideration in the last ten to fifteen years. Prior to that, Bourne, writing in 1924, stated that while records of cases which he had, frequently supplied detailed descriptions of the labours, there was often "only the scantiest

details on the insanity or any factors of aetiological importance" and it was because of this, it was difficult, as far as he was concerned, to give any very adequate account of the subject. This, no doubt, was more particularly so in view of the fact that Bourne was primarily an obstetrician, and as a general rule it is unlikely that in maternity hospitals, aspects of interest to the psychiatrist would be recorded in detail. Since Bourne wrote about his own particular difficulties in assessing the importance of these aetiological factors, Zilboorg in 1930, attempted, by detailed examination of a number of case histories of patients suffering from schizophrenia following childbirth, to assess the possibility of predicting the breakdown and thus being able to suggest means of prophylaxis. He came to the conclusion that this was seldom possible because the particular maladjustments which he thought these patients showed, only became clear after the illness had developed. He did suggest, however, that at a future date, "when preventive psychiatry had gained a higher level of psychogenic systematisation and a more extensive body of known facts with regard to psychodynamics of human development," that what then seemed to him to be a difficult task, might become a possibility.

Piker, in 1938, emphasized the necessity for the obstetrician to become thoroughly acquainted with his patient as a personality rather than exclusively with her pelvic outlet. He thought that the patient should be viewed as a psychobiologic unit, the different constituents of which were intimately interrelated. He thought that the obstetrician should interest himself in "the complete personal and physical lives, past and present, of their patients, and that he should know whether the patient was possessed of psychobiologic fitness for marriage", although he admitted that this involved considerable expenditure of time. He says of the doctor "if his conscience does not force him to investigate his cases from every angle and to measure emotional potentialities and repair mental trauma as he does pelvic diameters and perineal tears, he is only half a physician". He suggested that the psychiatrist could help in this but in the majority of cases he felt that properly interested management on the part of the obstetrician would eliminate the need for specialist psychiatric aid. He added that in the past decade an attempt had been made to anticipate mental and emotional difficulties through an alliance between paediatricians and psychiatrists, and said "It seems to me that we might well begin our prophylactic approach at an even earlier developmental level. If we want well adjusted children we must strive for emotionally

efficient motherhood. To the obstetrician is given the opportunity for preparing the way." Although in theory one cannot but be in complete agreement with the ideas stated by Piker, from a purely practical point of view the amount of time which would have to be spent in really getting to know the patient as a total personality and the environmental influences which had acted upon that personality since earliest childhood would be considerable, and more than the obstetrician could be expected to spend.

In 1941 Margaret Fries also suggested that an improved co-operative relationship with the patient during pregnancy would decrease maternal mortality and morbidity. She particularly emphasized the need for this in the interests of the child yet to be born. She pointed out that it would be easy to prepare an emotionally healthy background for the child, because firstly, the mother is already attending the doctor of her own free will because of her pregnancy, and secondly there are not yet feelings of guilt present over errors in handling the child, and that by tackling the mother's difficulties ante-natally, the whole family might be integrated through her, thus sparing the baby from her difficulties, early in life.

In 1942 Lloyd Thompson, studying normal cases at a pre-natal clinic, noted two-thirds of the primiparae wanted help by talking over any and all

problems with the physician, not only for advice but also for understanding of, and for, themselves. He recognised the fact that in any busy clinic there is little opportunity for the prospective mother to talk with the obstetrician about her attitudes, problems and misconceptions, whereas in the psychiatric interviews he arranged it became possible, and many women spoke about the opportunity they had had to discuss stored-up questions or fears which they had wanted to bring to a doctor. Only three out of all his cases showed evidence of resistance or reluctance to talk about personal topics.

Ian Skottowe in 1942 felt that half of all the cases of mental illness occurring in relation to childbirth were predictable. He was one of the few authors, also, who thought that termination should be considered if a patient with recognisable causal factors and any psychiatric symptoms, whatever, were seen in early pregnancy. The recognisable causal factors he listed under three headings as heredity, history of previous faulty attitudes to life situations, and obvious bodily or mental additional stresses.

In 1943 several writers have gone into the question of prophylaxis. Chapman thought that psychotherapy should be applied ante-partum to encourage the mother, that she would be able to care for the child despite all adversity and that life would be more satisfactory with the child in

the home. Stewart noted the necessity of early diagnosis by the obstetrician and suggested that as a means of obtaining this, a fuller history would help. The history he felt should take into consideration particularly the family background; the marital status and the sex life; the economic conditions and family burdens, concern over elders and difficulties in the upbringing of any other children in the family. Cohen suggested that if the obstetrician had time he should endeavour to explore and ventilate any of the patient's fears. In relation to this he gives a long list of particular lines which he feels should be investigated. He felt that an unwanted child was always an important factor and that the question of this should be gone into, in order to ascertain whether in fact the pregnancy was due to unsuccessful contraception or an abortion unsuccessfully attempted. Further reasons he felt for rejecting the child, and which should be looked for, were discrepancies between economic circumstances and standards set by the patient, the number and recency of the various pregnancies; fear of disruption of a previously happy marital situation, or a satisfactory job; an unhappy marriage, or some disturbance in the husband's attitude towards childbirth, or fears related to the physical and social limitations imposed by pregnancy. He further felt that the reasons for having a child should be considered and that if it were looked upon as a means to an end,

for example, to keep the husband or to mend a broken marriage, that this should be regarded in an unsatisfactory light. The patient's attitude towards the pregnancy from the physical point of view should be considered, particularly in relation to her attitudes to breast feeding and any tendency to think that by so doing she would be disfigured physically later. In any case where there had been a previous abortion or an unsuccessful attempt at it, there might well be guilt over this or fears of having damaged the child and this should be discussed with the patient. Fatigue, and the attitudes of the other children towards the mother, he considered to be important, especially if they were not getting enough attention. In many cases primiparae often felt that they would be unable to give the child the care that it needed. Another problem which he quoted as worrying many women in pregnancy was that of intercourse, so that many were torn between fears that continence would damage their husbands, or on the other hand that continuation of intercourse during pregnancy might damage mother or child. Some women, he felt, were unable to accept the change in status from the pregnant woman to the mother, feeling that they were no longer an object of special concern and must now accept responsibility, learn to care for the baby, and cope with it as well as their household routine and the changes in inter-family relationships. These women, he felt,

would benefit from being able to talk about these difficulties. In support of his contention that it would be advisable for this type of exploration and ventilation during pregnancy, he pointed out that Dersheimer in 1946 noted that delivery was one hour shorter if psychiatric supervision had been given during gestation. Jacobs also writing in 1943 stressed the importance of psychotherapy in the ante-natal period.

From what has already been said in relation to points brought out by other authors, it was considered that the 25 cases in this thesis should be studied in order to assess the possibility of any form of prevention which might have been undertaken to avoid mental breakdown following childbirth.

In the multiparae there do seem to have been possibilities of prediction although never with absolute certainty. The group of six multiparae with previous puerperal breakdowns in each pregnancy were all obviously cases which should have come under close observation during the gestational period, more particularly the three who showed, in addition, breakdowns unrelated to pregnancy. It will be noted in those three cases that in Case F.H.(25) the difficulty lay mainly within her own personality, whilst in Cases M.A. and W.S. (13 and 23) both had marked hereditary factors and were subject to manic-depressive cycling. In addition, W.S. (23) had a somewhat difficult life situation

to contend with, thus making the possibility of a breakdown even more likely. The other multiparae in the group who had broken down at every pregnancy all showed difficult life situations of one sort or another and Case V.P. (19) had the additional factor of an unstable personality. In Case E.L. (16) it is quite clear that the conflict which caused her first puerperal breakdown remained as a persistent problem and was responsible for her second puerperal illness. Case R.E.W. (17) showed considerable anxiety about miscarriages early in her marriage, as she was particularly anxious to have a child, and was extremely upset by the inconsiderate nursing and other misadventures during labour. To her the process of conceiving and bearing a child must have seemed fraught with danger so that before she had scarcely recovered from a mental illness which occurred after the birth of the first child she found herself pregnant again. It is, therefore scarcely surprising that she broke down early in this second pregnancy: in her case, as well as those of the other five, it seems possible that the breakdowns could have been predicted.

Out of the other multiparae it would seem that knowing that Case N.C. (24) and Case A.K. (21) had both had breakdowns unrelated to childbirth, and both in addition had disturbed marital situations to cope with, that these two should also have come under particularly close observation during pregnancy.

The fact that Case M.C. (12) had had one normal labour would not probably have deterred a careful observer from assuming that she would need special help during a subsequent labour after her case history had been examined closely. She had a depressive illness unrelated to childbirth altogether and since then had had an increasingly difficult life situation in her home background to cope with. Case M.L. (20) could also have been helped in pregnancy although the breakdown she had unrelated to childbirth occurred much later in life, and therefore would have been no help in predicting a puerperal mental illness. Her faulty attitudes towards childbirth, and the considerable fears that she had regarding labour, which were made much worse by the gossip of her neighbours, might well have been dispelled by an opportunity to discuss her doubts and fears prior to labour. It is of interest to note that when she came to have her second child she did so with a more certain knowledge of the process of labour and in fact did not break down. Certainly the presence of these faulty attitudes towards childbirth might well have helped in predicting a possible breakdown.

Case E.D. (15) could possibly have been spared her illness as it was undoubtedly largely precipitated by her appalling marital and social circumstances from which she felt there was no escape. Again if there had been an opportunity

ante-natally of obtaining help this might have been avoided. At the same time her guilt regarding her previous attempt at self-induced abortion might have been ventilated, as it too, no doubt, played a part in her ultimate breakdown.

Case M.B. (14) was quite certain that she could not cope with a third child and in view of her bad heredity and certain personality difficulties, much could have been done to avoid a breakdown. In any case the positive family history would have brought her under close observation during the ante-natal period and at that time her attitude regarding the birth of a third child could have been ascertained. Case R.H. (18) showed severe personality difficulties and in view of the fact that she had already had one puerperal breakdown she should automatically have come under observation at which time her extreme attitudes regarding bearing only male children, and the difficulties of her marital situation could have been assessed and dealt with.

Case A.S. (22) was again probably a predictable case. Her previous puerperal breakdown should have brought her under observation, at which time it could have been noted that the social circumstances under which she was living were extremely difficult. In addition there was a considerable amount of evidence that her personality structure was not such as to stand up to these various additional strains and stresses.

As has already been noted, nine out of these fourteen cases were already showing symptoms in pregnancy so that this too would have been an additional reason why breakdown could have been anticipated and earlier steps taken to prevent it.

From the point of view of prediction of mental illness the primiparae are considered separately as there was no previous pregnancy to act as a guide. There were, however, three in which there had been previous breakdowns and these automatically should have come under close observation during pregnancy.

Case 5. J.S. showed definite evidence of an unstable previous personality and the fact that she was having an illegitimate child made it extremely likely that her particular personality structure would not stand up to this strain.

Case 1. A.V. had an unstable personality and showed evidence in the past of being unwilling to accept responsibility. In addition to that she had a difficult marital situation, and in hospital received inconsiderate nursing during her labour. Although in view of her personality structure and the difficulties of her marital situation it might have been possible to (at least) suspect a forthcoming breakdown, there was in any case the fact that she had already had a breakdown unrelated to pregnancy and this should have brought her under close observation during the ante-natal period.

Case 10. B.E. Is one of the cases where it would have been extremely hard to predict a mental breakdown following childbirth. The only point which would have brought her under observation was the fact that she had had a previous apparently schizophrenic breakdown at the time of her engagement. The positive family history which has been recorded would not have been of any help as the member of her family who became psychotic was a brother who did not become ill until the patient herself had already broken down. If, however, an adequate description of the previous breakdown at the time of her engagement could have been obtained, it seems likely from the mere nature of that illness that one would have kept

a careful watch over her ante-natally. In spite of this observation there is little that could have been done to prevent a breakdown apart from discouraging her from bearing children in the first place.

The remainder of the primiparae, eight in number, showed a varying admixture of personality, life situation and heredity factors. Because they had no previous breakdowns and had never passed through the experience of childbirth before, there was no concrete guide to the possibility of the breakdown. However, if these cases are studied more closely it will be seen that:-

Case 6. M.H. who had subsequent breakdowns following puerperal illness had also considerable personality difficulties and in addition faulty attitudes to childbearing.

Case 2. I.M. also had severe personality difficulties with inability to accept responsibility, which trait extended to the upbringing of a child. In addition she had a positive family history which should have brought her under observation during gestation, when it might have been possible to predict that there was a likelihood of breakdown because of this combination of factors.

Case 3. R.W. showed faulty attitudes to childbirth in general of a very marked nature as well as an extremely difficult and involved marital situation owing to her relationship with someone else other than her husband. The stresses and strains which were produced by this relationship might well have been expected to produce a breakdown, in this personality.

Case 4. E.H. should have come under observation because of the family history and at that time her faulty attitudes towards childbirth and the rearing of children would have been noted. With these two factors present it might have been expected that the conditions under which she had her child were more than likely to produce a breakdown.

Case 7. S.R. In this case there was no indication from the family history or the patient's previous psychiatric history that there were adverse constitutional factors. With her the main difficulty

seems to have been an extremely adverse life situation during the time of her pregnancy. At first, after her marriage she lived quite happily with her husband in her own parental home. At about the time she became pregnant she moved to live with her parents-in-law where they were given inadequate space in a large house and she constantly came under criticism from the mother-in-law who was extremely domineering and during the months of her pregnancy the relationship between the two women became steadily worse. As it was a feature of this patient's personality to keep difficulties to herself and try at all costs to avoid trouble, she endured these adverse circumstances where another woman might have tried to do something about it. It was these conditions, one feels, which might have been dealt with by an outside agent during her pregnancy and in this way it is possible that a breakdown could have been prevented.

Case 8. J.W. Although there were no adverse factors in this patient's heredity which might have drawn attention to her case ante-natally, discussion with her during gestation could well have revealed various important factors. She was extremely upset by a miscarriage which occurred a short time before the present pregnancy and this upset seems to have been based on her feelings of having to make up to her husband for his intellectual superiority in the marriage. This might well have made a psychiatric observer feel that too much importance was being attached to the birth of this particular child. Her reaction to the child being born with the congenital defect of the eye, was hardly surprising and one feels that had she had careful psychiatric handling during that time she might have been able to make an adequate adjustment.

Case 9. M.D.H. This is on the whole another case where one feels it would have been extremely difficult to predict a possible breakdown following delivery. To all intents and purposes there were no adverse factors in this case from the constitutional point of view and her marital and social circumstances appear to have been perfectly satisfactory. She was anxious to have the child but not unduly so. Her personality structure, although of the sensitive, undemonstrative, self-conscious, withdrawn type, was not markedly so and she had been able to make various friends and take part in a reasonable social life. It is interesting to note the lack of factors here which might have made a prediction possible as this was a schizophrenic type of reaction. The only other case where prediction would have seemed equally difficult was

Case B.E. (10) whose reaction type was also schizophrenic, although in this case there had been previous non-puerperal breakdowns.

Case 11. M.J.C. This patient had a positive family history which should have brought her under observation during the ante-natal period. It ought also to have been possible to assess during gestation the immaturity of the patient and the difficulties that this immaturity was producing in forming a secure adult marital relationship. The fact that she did not want a child so soon after marriage was no doubt related in her case to the fact that she was not yet secure enough to embark upon motherhood. Her personality structure was of the reserved, shy but moody type and she was easily upset by even minor matters. The fact that she and her husband had no very adequate place to live and were in fear of being ejected by the landlady as soon as she had the child, must have added to their troubles. With help during the ante-natal period one feels this patient might have approached pregnancy with a calmer mind. Her handling by the hospital when she was overdue was not particularly good. She saw other patients in labour before her own turn had come and was sent home to wait until she went into labour. It was also suggested that she should appear for an M.D. examination and all these facts must have given her the impression that there was something abnormal about her pregnancy and increased her tension and anxiety. It is possible that with more careful handling, therefore, the breakdown might have been avoided.

The possibilities of prediction of mental disorders occurring in relation to childbirth have been considered in these twenty-five cases in order to suggest means of prophylaxis.

It is not the purpose of this thesis to suggest measures to present the inheritance of mental disorder, for that is the province of geneticist, nor is it intended to deal here with the prevention of childhood neurotic symptoms produced by faulty early backgrounds, for this is the problem of the child psychiatrist. Where marital disharmonies of the parents result in disturbance of the child, then this too will be dealt with by the child psychiatrist and the social workers attached to their clinics. The measures suggested here will be mainly those which might prove helpful in dealing with difficulties which are still possible of adjustment when the patient comes to the ante-natal clinic. Although they will be primarily designed

to this end one cannot overlook the possible subsidiary benefits which might arise for the child yet unborn if the marital difficulties and faulty attitudes of their parents were to be dealt with at this early stage. One hopes, in fact, that in this way much of the child psychiatrist's time may be saved in the future, or that where there are severe personality difficulties in the patient that an early link may be made with the child psychiatrist. Apart from these side lines the possible prophylactic measures which might be adopted to prevent mental illness in relation to childbirth are various and will now be considered.

Because of time and other factors involved, one feels that a detailed study of these cases antenatally falls more into the province of the psychiatrist than the obstetrician. The difficulty then arises as to which cases the psychiatrist should be called upon to see. Obviously it would be equally impracticable for the psychiatrist to see all pregnant women, many of whom had no particular personality or environmental difficulties. It seems therefore that some intermediary between the psychiatrist and the obstetrician is necessary and the type of person that immediately comes to mind is the psychiatric social worker. Obviously, however, her knowledge and ability to assess the relative requirements of each case is not sufficiently specialised for her to deal with the whole problem. It was felt, however, from the material studied in this thesis that certain

fairly definite pointers, particularly related to a more specialised form of history taking in these cases, could be given to the P.S.W. so that in fact a preliminary sorting out process could be done by her. There seems no objection, therefore, to there being a psychiatric social worker appointed to every ante-natal clinic in the same way as there is, for example, a venereologist, so that each patient going through the clinic would accept it as a matter of routine to be examined by this person.

From the material studied in this thesis it was felt that it was possible to assess the relative importance of several factors which might operate in each individual case. In some instances it was felt that difficult environmental situations played the sole part and where these were present there seems little reason why the psychiatric social worker could not deal with them herself. There is, of course, an obstetric almoner, usually connected with most ante-natal clinics, but as already stated in the introduction at the present time these workers are encouraged not to seek the facts but rather to avoid them, treating childbirth as a normal physiological process. In any case the obstetric almoner is not trained in the same way as the psychiatric social worker to look for the facts that one feels it might be important in these cases. Apart from the purely environmental difficulties cases showing unfavourable heredity, unstable personalities, and faulty attitudes to childbearing,

could be selected by her reasonably easily and referred to the psychiatrist. In this way each P.S.W. connected with an ante-natal clinic could be working under one single psychiatric. The number of P.S.Ws. to each ante-natal clinic would depend on the size of the clinic.

The psychiatric social workers would of course need to have some special knowledge of the physiological problems of childbirth, in the same way that those working with children are supposed to have more than a general knowledge of children. In cases which require treatment by the psychiatrist, it should not be too difficult a task for the obstetrician and the psychiatrist to co-operate in the handling of the cases throughout pregnancy and labour. In other branches of medicine this had been done quite satisfactorily.

The more detailed study that has already been made of these twenty five cases and the tables provided to indicate where adverse life situations, personality or heredity factors played the greatest part, may now be used to show in which cases it is felt that the psychiatric social worker alone would be capable of handling the difficulty, and in which a psychiatrist, or a combination of psychiatrist and P.S.W. might have been expected to ease the situation for the patient.

PSYCHIATRIST.

Case 25. F.H.
13. M.A.
23. W.S.
18. R.H.
10. B.E.
1. A.V.
14. M.B.
16. E.L.
17. R.E.W.
2. I.M.
3. R.W.
8. J.W.
11. M.J.C.

PSYCHIATRIC SOCIAL WORKER.

Case 24. N.C.
21. A.K.
12. M.C.
15. E.D.
5. J.S.
7. S.R.

PSYCHIATRIST AND PSYCHIATRIC SOCIAL WORKER.

Case 20. M.L.
22. A.S.
19. V.P.
6. M.H.
4. E.H.

It will be noted that these cases total twenty four. As it was felt that one of the schizophrenic cases (M.D.H.) showed no evidence of any adverse factors, it would have been impossible to predict that she might have a breakdown following childbirth, and therefore in this one alone no steps would have been taken to prevent it.

The type of history taken by the psychiatric social worker should be based on the general scheme used in the cases reported here, but certain items should be particularly emphasized; firstly the family history from the point of view of assessing the heredity, secondly the early home background seems worthy of particular note, in view of the fact

that such a large proportion of these cases showed disturbance in the parental marital situation or other abnormal parental situations, such as step-parents, etc. Neurotic symptoms in the patient in childhood should be specially noted as they were present in a high proportion in these twenty five cases, possibly due to the fact that so many had a difficult early background.

The third point of importance is the personality of the individual. Here special emphasis should be laid upon the work record as a general indicator of stability. High standards, or obsessional features appear to be of importance as many of the cases in this series showed an inability to adjust their standards to the added burden of a young baby in the household, particularly where their previous standards had been exceptionally high. Information concerning over-anxiety about minor matters and marked mood swings, should be sought in the personality study. Ambitiousness as a single feature might also be noted and more particularly what that ambition is related to, for in these cases where the goals were intellectual in nature it frequently resulted in conflict in the patient when childbirth was felt to cut across these ambitions. Male sex preference, whether in relation to themselves, the type of company they prefer, or preference in relation to the child, is also of importance, as a fair number of these twenty five cases showed this feature and where it is strongly present may produce

trouble either because the patient is unable to accept the woman's role, or is disappointed by the birth of a female child. Hypochondriasis may be noted although as an individual indicator it is of little value. In this series of cases those who showed hypochondriasis during the illness were not notably hypochondriacal personalities prior to their breakdowns, while conversely those that were hypochondriacal personalities prior to breakdown often did not manifest this feature in their illness. Over-dependence on either of the parents should also be noted. There was a fairly high incidence of over-dependence on the mother in particular in these cases and where this factor was present there was evidence of a more general insecurity in the patient. As opposed to 40% who were over-dependent on the mother, 20% were over-dependent on the father and in these cases the identification with the father in itself had often led to difficulties in assuming the role of a woman, particularly in relation to motherhood. As well as studying the personality, difficult life situations should be looked for, particularly in the marital history and a special note made of the stability or otherwise, of the husband as in many of these cases the husband showed some major or minor personality deviation. From this point of view it seems that it would be as well to interview the husband as a matter of routine in every case. This should not be difficult if it were a customary arrangement that the husband attended

the ante-natal clinic with the wife at the first visit.

In addition to consideration of the marriage, attitudes of the patient towards childbirth in general and to this pregnancy in particular should be very well reviewed, as this series of cases showed a high proportion in which the child in question was unwanted, while in some there was a conscious rejection of motherhood in general which obviously should have been dealt with at a very early date in the pregnancy. Their fears and doubts regarding labour itself ought to be gone into thoroughly, as a number of the cases in this series had completely erroneous ideas about the mechanisms and dangers of labour, and in any case, as was stated by Derscheimer, tackling this problem in the ante-natal period, even in woman who did not break down, shortened the duration of labour by one hour. Ernest Jones in 1942 also emphasised the importance of the woman's attitude to labour and related these attitudes to the nervous mechanism of the normal expulsive movements.

Over and above these more specific points all possible social difficulties should be gone into fully with the patient, whether they be overcrowding, living with in-laws, financial difficulties etc. This type of history then, could be taken by the psychiatric social workers connected to the ante-natal clinic. The psychiatrist should see all cases with a positive family history. Although on the

whole termination of a pregnancy should never be recommended lightly, in those whose family history is positive and who show repeated breakdowns in every pregnancy as well as breakdowns unrelated to pregnancy, this step seems essential. In addition the psychiatrist should see those cases with personality difficulties. Where these difficulties are fairly mild, ones that can be dealt with on more or less supportive lines, and handed back to the P.S.W. for further interviews. It is, however, with more severe personality difficulties, and in particular those cases which show faulty attitudes to motherhood, that the psychiatrist should keep them on for further treatment. Where there are difficult life situations, which relate to social problems, these cases could be handed back to the P.S.W. for management but those of a non-social nature should be kept on by the psychiatrist for further psychotherapy.

The other group of cases which should be seen by the psychiatrist are those who develop symptoms of psychiatric illness during pregnancy, however mild in nature, and regardless of whether they show any of the particular problems which have already been noted.

It is in relation to the cases that are quite definitely in need of treatment and continuing interviews with the psychiatrist during gestation that special co-operation between the psychiatrist and the obstetrician should be maintained. To this

end, regular interviews for discussion of difficult cases might be organised. In relation to this arises the problem of handling during labour. Broadly speaking it seems that all maternity hospital staffs should have, during their training, some psychiatric education pertaining to the problems of childbirth; and the importance of correct handling from a psychological point of view, of women during pregnancy and labour could be even further emphasized. This is particularly stressed by the fact that out of these twenty five cases 7% showed inconsiderate nursing during and immediately after parturition and in some of these cases it was felt that that in itself had played a very large part in the onset of the present illness. Even more important is that the nursing staff should be aware to some extent of the problems of the patients who have been under special psychiatric care during the ante-natal period and detailed instruction given to them as to the handling of the patient throughout the labour.

These measures are all designed to deal with the group of patients which attend hospital ante-natal clinics during pregnancy and are to be delivered in hospital. It leaves completely untouched numerous cases who are delivered at home and who attend their general practitioner for ante-natal examination. It seems therefore, that this drive towards the better understanding of the pregnant woman as an individual with specific problems, should also include the

general practitioner. It ought to be possible to give him a better understanding of the type of problems and difficulties which may arise at this time and their importance in the production of mental illness following delivery. Just as the general practitioner has become accustomed to send cases with pelvic disproportion or toxæmia of pregnancy to hospital, so should he also be encouraged to send those patients who constitute psychiatric risks to the ante-natal clinics which are provided with psychiatric social workers and psychiatrists. If the general practitioner were able to select even those cases with a bad heredity, previous breakdowns, unstable personalities, unalterable and difficult life situations, that in itself might constitute a large group who ran the greatest risk of breaking down following parturition. Certainly any cases seen by the general practitioner during pregnancy who already showed even the mildest symptoms of psychiatric disorder at that time should be referred without delay. It seems better that those with early symptoms should be referred to the ante-natal clinics rather than to the out-patient department of a psychiatric hospital, as it is hoped that if the measures suggested here are instituted, the psychiatric staffs of ante-natal clinics will be trained to deal more specifically with the psychological problems relating to childbirth.

NOTES ON TREATMENT.

The material studied in this thesis was not specially considered from the point of view of treatment but certain interesting points have come to light. Various authors Henderson, Tod and Daly; Jacobs; Feldman, Susselman, Lipetz and Barrera, and others have recommended E.C.T. for the treatment of mental disorders associated with childbirth. The result of E.C.T. in this case material was not impressive. Twelve cases had E.C.T, but in only five was the response to treatment entirely satisfactory. In the other seven this was not the case and although a few of them responded temporarily to treatment they rapidly relapsed again, while others failed to respond at all. Possibly the failure of E.C.T. in a proportion of cases was due to the fact that many of them had a considerable amount of reactive anxiety superimposed on their depressions. No doubt much of the anxiety in these cases arises from an extremely complicated psychopathology, which can only be dealt with by a psychotherapeutic approach.

Deutsch, in her book on the "Psychology of Women", makes the complexity of these psychological ramifications even in the normal pregnant woman, only too clear. In the 25 patients studied here, many of the mechanisms discussed by Deutsch were noted, and as she says "the sense of guilt that dwells in every human soul particularly burdens the reproductive processes". According to that author, motherhood and pregnancy are laden with old guilt feelings, and these lend greater power to the guilt motives acquired

later. This is only too well borne out in a number of cases in this thesis. Deutsch emphasises also the difference between "motherliness" and "motherhood". She describes motherliness as a complex structure and not merely an emotional unit, and points out how the lack of this may make adjustment to motherhood itself difficult, if not impossible. In a number of these cases lack of "motherliness" was a marked feature of their personalities and a constant preoccupation during their illness. Cases M.C., E.H., R.W., and M.H. are outstanding examples. Deutsch also points out "that the harmonious course of pregnancy presupposes many factors; above all a definite emotional maturity in the pregnant woman, a sufficient amount of psychic and physical health and fairly favourable environment conditions, among which rank first, the marital situation, then social and economic factors, etc". She points out in addition that "social necessity, fear of real obligations, the limitation of personal freedom, and last but not least, the masculinisation of feminine interests and occupations have not only contributed to the devaluation of fertility, but even threaten to weaken the normal biologic and emotional urge to reproduction". Again, one feels that these statements are only too true, particularly in relation to the case material studied here. If, in fact, the trend of life to-day tends, as she says, to emphasise the difficulties of the reproductive period, then also it should emphasize the growing need for adequate antenatal supervision and care of the pregnant woman in order to make compensatory adjustments possible at the outset.

S U M M A R Y.

It was pointed out in the introduction to this thesis that although much attention has been paid to the improvement of ante-natal services from a physical standpoint, little appears to have been done in the equally important psychological and social spheres.

A general survey shows that although the figures on the incidence of mental disorder related to childbirth vary widely, Ripping quoted the highest figure as being 21.6% of all female mental hospital admissions, but that generally speaking most authors place it between 5-10% of all female admissions. Considering the problem from a slightly different viewpoint, the majority of writers think that between 1 in 400 to 1 in 1000 deliveries result in the mother becoming mentally ill. Stewart, in 1943, and Kraines in 1941, stated that the incidence of childbirth psychoses was at least twice as high as psychoses in the general female population. The fact that the incidence may well be higher than the figures already quoted is emphasized by Boyd, Piker and Zilboorg. These authors point out that many other cases may never be seen by the psychiatrist as their disturbances are either too transient or too mild and pass unnoticed by the non-psychiatric observer. On the other hand, many do not develop their symptoms till some time after delivery and in these the connection between childbirth and the mental illness is overlooked.

Findings on prognosis showed that although on the whole most of the affective , or delirial types of illness recovered, that the schizophrenic reactions rarely did so. Even in those mental states which offered a better prognosis, a long period of hospitalisation was required and there were even then considerable chances of an incomplete recovery. Adverse circumstances in the environment, previous personality, or heredity, of the patient were considered to jeopardise complete recovery even further.

In view of these findings it was felt that a re-valuation of possible precipitating factors should be undertaken in an attempt to suggest practical lines of prophylaxis.

It was decided, therefore, to study a further group of women suffering from mental illnesses which were related to childbirth and in whom life histories and background were known in considerable and accurate detail. All were serious enough illnesses to require treatment in hospital, but as the group was so small, being only twenty-five in number, it was realised that any conclusions reached could not be considered as entirely reliable. Added to this, the impossibilities already described in obtaining a normal control group made statistical evaluation useless. Nevertheless, it was felt that particularly in mental illness related to the reproductive period, the detailed study of the individual's past life and attitudes was of even more importance than the comparison of the disturbed woman with her other more fortunate sister. H. Deutsch

sums up very adequately by saying "the great experiences of our lives are not isolated but linked together in a long chain. In studying woman's reproductive function, we are constantly confronted with the re-emergence of past situations, frequently traumatic in character. Successful mastering of the past is a pre-requisite for woman's psychic health, otherwise new situations provoke new traumas."

Each of the cases in this thesis was examined in detail in regard to aetiology leading up to the present mental disorders. Heredity, disturbed early home backgrounds, previous personalities, adverse social factors, disturbed marital situations, attitudes and fears related to childbirth or the care of children, difficult labours or inconsiderate nursing, and feeding difficulties were all analysed and discussed in detail in the appropriate sections. Further, the content of thought in the illness was examined for evidence of any expression of the difficulties which might have been present prior to the onset of the illness.

An attempt to balance them as to their relative importance was made separately in the case of the multiparae and the primiparae, taking only the three broadest sub-divisions of "Heredity", "Adverse Life Situations" and "Personality". It was found that in most cases there were a number of varying factors but that it was possible in the majority to implicate a particular one more than another.

In considering heredity it was found that a positive family history was present in one-third

of the cases, on the other hand the incidence of drunkenness, psychopathy, or marked mood variations, was much higher and amounted to one-half of the total number of cases. Study of the early environment showed that 76% of the cases had parents whose marital relationship was disturbed or had other abnormal parental situations, e.g., step-parents. In childhood 76% of the patients showed neurotic symptoms, although only 60% of those with neurotic symptoms had disturbances in the parental situation.

Certain definite personality features in the various patients were noted and discussed.

In 72% of the cases an adverse life situation was present although in some instances other factors were also operative in the same individual. The importance of adverse life situations was further emphasized by dividing the multiparae into three groups. In this way it could be demonstrated that where a woman had had normal pregnancies the life situations at the time of the pregnancy associated with the mental illness had been more adverse than on the other occasions. In addition, it was shown that in women who had broken down at every pregnancy there was either some marked underlying personality defect (especially associated with attitudes to childbirth) or an adverse heredity, or a difficult life situation which had persisted throughout. In addition to these facts evidence of prodromal symptoms in pregnancy was looked for and found in 66% of the cases studied. An attempt

was made to assess the possibilities of predicting a forthcoming breakdown on the basis of the previous conclusions and in all but one case it was considered that such prediction should have been possible, if the above mentioned factors had been taken into consideration by an adequately trained person.

Suggestions for possible prophylaxis were made.

The twenty-five cases studied here were divided according to the nature of their difficulties into those who might have been treated by a psychiatrist, those who might have been helped by a P.S.W. and those who would have required the assistance of both. From

this it could be seen that there was definitely a place for the services of psychiatric social workers in ante-natal clinics. Twenty-four per cent of the cases studied here might have been looked after by a P.S.W.

as their problems were largely of a social nature, and twenty per cent by a psychiatric social worker and psychiatrist together. As a larger number, 52%, should

have had the care of a psychiatrist, it was felt that the psychiatric social workers should also have the duty of originally interviewing each woman passing through the clinic in order to make a preliminary selection of cases who might possibly need help.

She would be attached to a psychiatrist who could in this way supervise a number of ante-natal clinics.

His work would consist of the final selection of cases to be treated, the decision as to whom they should be treated by, and the actual treatment of the cases with more difficult personality problems. A further duty of the psychiatrist should be the education of

the maternity hospital nursing staff in the psychological problems of childbearing. The need for this is well shown in the sort of treatment that twenty eight per cent of the patients in this series received while they were in the maternity hospital.

Lastly it was suggested that the general practitioner should be encouraged to make use of the ante-natal psychiatric services provided.

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A P P E N D I X.

CASE MATERIAL.

Case 1. A.V. Aged 33. Primipara. Admitted 7. 8. 46.
Home address - North West London.

Reason for Referral. Anxiety, depression and inability to cope with the domestic situation starting 14 days following childbirth on 3. 6. 46.

Family History. The father, now aged 53, was formerly an acetylene welder, but has been a hairdresser for many years. He was in the habit of drinking heavily. The patient was very frightened of him and would hide when he came home drunk, although at other times he did not take much interest in the children. He gambled a lot which led to rows with his wife during which, on occasions, he would strike her. The mother was of a placid and even disposition and good to her children. The patient was the eldest of the four children, two of the others being rather lazy and shiftless people but otherwise normal. There was no family history of mental disorder.

Personal History. The patient was a premature baby, and "highly strung" as a child, with frequent sleep-walking. She was a good scholar, reached the top class, in which she held second place and left school when she was 14. She went to work as a filing clerk after leaving school but didn't like it and would frequently retch all the way to work. She gave it up and went to factory work but disliked the dirt so much that she gave this up after about 3 days and stayed at home thereafter till she was 16½. She had several different jobs following that, often leaving for inadequate reasons. Her periods started when she was 11½. Their onset was not traumatic and there were no psychic changes associated with them. She met her husband in 1935 and nine months after their first meeting, they started to have intercourse. In December 1939 they married. The husband was 3 years older than the patient, a bank clerk, and rather an unstable and cynical man with some obsessional features. Three days after their marriage he formed a liaison with a woman at the bank which lasted six months, the patient hearing about it through an anonymous letter. She was very upset when she discovered it and threatened to leave him. After the affair came to an end, they lived reasonably happily together, but were sexually poorly adjusted, the patient frequently not reaching orgasm. In the early days of their marriage, her two brothers-in-law lived with them, one of whom had disseminated sclerosis. She found this too much to cope with until one left, but the other, however, continued to live with them. He has been a great deal more considerate to her than her husband and she has at times felt that she had more affection for him than for her husband. In 1943 she developed anorexia and depression and was

treated as an out-patient at another hospital, until she recovered 7 weeks later. During this time her husband was most unsympathetic towards her, would come in at night, cook his own meal and then go out again and leave her. Shortly after this he was called up, and has been serving in the R.A.F. since then although seeing the patient fairly frequently. In September 1945 the patient became pregnant, she was very well and happy throughout her pregnancy and wanted the child.

Previous Personality. The patient always tended to be rather pessimistic, although there were no true mood swings. She always disliked hard work, but enjoyed dancing and the cinema and has been able to mix easily with people.

History of Present Illness. The patient had a straightforward delivery, but sustained a severe tear when a baby girl was born on 3. 6. 46. There was a shortage of staff in the hospital and she was frequently given contradictory instructions by sister and nurses, so that she felt she never could do the right thing. Finally, 10 days after the birth, she had diarrhoea which lasted for 3 days. On two occasions also she was incontinent and was made to clean up after herself which upset her. A fortnight later she went home and her brother-in-law looked after her till the husband came home on compassionate leave. The baby cried all night and the patient was unable to sleep. She had cracked nipples causing her much pain but persisted with breast feeding. She began to worry about all the things she would have to cope with, rations, the baby, etc., and also that, after having had 7 years freedom, she would now not be able to go out. She ruminated more and more about these things, became depressed, and felt the baby had come between herself and her husband and that she no longer had any affection for him. After 5 weeks at home she felt completely unable to cope, talked about committing suicide and became very agitated. At the end of July she went to her mother's house where she gradually became much better, able to concentrate on looking after the baby, and begin to make plans for the future. In spite of this improvement she was admitted to hospital at the beginning of August 1946.

State on Admission. Physically there was no abnormality. Mentally she was still mildly agitated, depressed and hopeless about the future and was rather aggressive about being admitted to hospital. Her memory and concentration were good, she was correctly orientated and of average intelligence.

Progress. She improved slightly for the first fortnight after admission but when her menstrual period started she relapsed again, blamed herself for having no feeling for the baby and for neglecting her appearance when she was ill at home. She continued to blame herself for her lack of interest in her husband and child and in view of her long-standing marital difficulties, wondered whether it was worth trying to make something of her marriage. She repeatedly talked of her resentment at being unable to go out in the future because of the baby. At the end of September the husband was asked to give permission for his wife to have E.C.T. He came up to the hospital, seemed a discontented, unstable, rather psychopathic personality, abused the doctors in their management of his wife's case, refused permission for treatment and insisted upon his wife discharging herself against advice. She was seen a month later at the Follow-up Clinic where she appeared to be free from depression, was very attached to the baby and said her relations with her husband were now much improved. She failed to attend for further appointments.

Diagnosis. Depression occurring during the puerperium in a woman of previously unstable personality with a difficult marital situation and a psychopathic husband.

Case 2. I.M. Aged 34. Primipara. Admitted 10. 11. 49.
Home Address - Middlesex.

Reason for Referral. Recurrence of depression following childbirth with difficulty in managing household affairs and baby's routine.

Family History. The father was an "erratic" man, a cable layer by trade and given to drinking heavily. He suffered from a gastric ulcer and had a corresponding temperament. He had no time for the patient when she was young and would often strike her, and he and the mother had frequent fights which the patient witnessed. He ultimately died in 1941 of cancer. The patient's mother was a more stable personality to whom the patient was very devoted and she and the mother ran away together on several occasions owing to the unhappiness of the home, but father always found them and brought them back. Since the war the mother has had several minor breakdowns during which she felt people were talking about her and locked herself in her home to avoid them. These spells lasted two months and between them she was quite normal

There was only one other child in the family apart from the patient, a younger brother who died of nephritis at $3\frac{1}{2}$ years. There was no other family history of mental disorder.

Personal History. As a child the patient was sensitive and rather shy and over-anxious to please people. She cried easily but showed no actual neurotic traits. She was an average scholar and left when she was 14 to go out to domestic service. She disliked this life intensely and was made to feel very inferior by her employer and finally left after 6 months. She subsequently became a shop assistant and was finally promoted to a floor walker. Although she was able to do the job quite well she lacked confidence in her own ability and when, finally, owing to staff cuts she returned to the counter she felt relieved and pleased. She joined the W.A.A.F. in 1941, was happy, but again unable to accept responsibility and refused her promotion to a Corporal. She had two or three boy-friends and more than one of them wanted to marry her, but in view of her own parents maladjusted marriage she had determined never to marry and would always break off her friendships with men when they became too serious about her. She was always rather prudish in sexual matters, and in her childhood days recalled having had sexual advances towards her by one middle-aged man, and being very frightened by it. Again later in life after having her photograph taken by an amateur photographer, she was frightened when she saw other photographs of nudes and felt sure that he would assault her when he asked her to help him develop her photograph in the dark room. Finally, while still in the W.A.A.F. she met her husband. He was 2 years older than herself, an engineer and a quiet, diffident fellow, who subsequently became so preoccupied with what others thought of him that he had to attend the Tavistock Clinic for psychotherapy. The patient felt that she had at last found someone who would understand her own diffidence and difficulties and decided to marry him. Even when it came to getting engaged she was so alarmed by the responsibilities she was taking on that it took three hours to persuade her to put on the engagement ring, which she actually lost soon afterwards. She finally married, however, in 1944, and soon after left the W.A.A.F. The marriage was a happy one, and although she was usually able to achieve orgasm during intercourse she was constantly tense and anxious in case she should not do so, often being left not completely satisfied. She was, however, unable to discuss it with her husband, being too inhibited. She used to worry also as to whether they had sexual intercourse with exactly the same frequency as everyone else. She felt that the responsibilities of a child would be too much for her, but eventually as her husband was anxious to have a family she did attempt to conceive. She remained infertile, however, and in 1947 went to a hospital for advice. She felt at this time

that she did honestly want a child, but was much upset when the doctor there implied that she had not tried hard enough. With advice regarding times of ovulation she soon became pregnant, however, but never really accepted the idea of the responsibilities of a child. Her pregnancy was normal except that on X-ray it was a breech presentation. She was admitted to hospital and delivered herself spontaneously and unexpectedly whilst unattended. She was not frightened by this but anxious for fear it should have injured the baby. Following the baby boy's birth in September 1948 she returned home and breast fed satisfactorily. She was quite happy with the child at first and when it was 3 months old she started to get over-anxious about it, worried whether its clothes were aired and if her milk were drying up. By December 1948 she began to believe herself a nuisance to everyone and became unable to tend the child. She eventually became afraid to go shopping as she thought that the shop assistants were offended by her and also that her friends tried to avoid her. Finally she developed mild suicidal ideas and in February 1949 was admitted to hospital. She was mildly depressed, retarded and self-reproachful for having failed in her duties. She had 4 E.C.T. and gradually recovered and returned home on 16. 5. 49. She was found to have a fibroid shortly afterwards and because she felt that some time she ought to have another child, she went into hospital to have an operation in June 1949.

Previous Personality. She was normally a bright, happy person but was very sensitive and easily hurt, although she quickly forgot a slight. She was always over-anxious to please people and was rather diffident and shy and did not mix easily.

History of Present Illness. Prior to her operation for fibroids her husband had had to sign a form giving permission for hysterectomy should this be necessary. This greatly upset the patient, although in fact, she only had a myomectomy done. She was depressed and tearful the day after the operation and tended to worry over trivialities up to the time of her discharge a month later. A fortnight after returning home, she again began to worry about the shopping and seemed to lose all system. She became anxious about the baby's future, for example his education, and felt she would never be able to cope with him, nor with his young friends and their parents. She blamed herself for lack of affection towards him when visitors made a fuss of him. She gradually became indecisive and blamed herself for everything, saying that she was a nuisance and her husband would be better off without her. She stated that she wished she had never recovered from the operation. Finally she was re-admitted to hospital on 10. 11. 49.

State on Admission. Physically, there was no abnormality. Mentally, she was extremely tense, anxious, and depressed. She blamed herself for ever getting married and for her inability to cope with household affairs. She felt she ought never to have another child after making such a trouble of this one and was guilty about being forced by her illness to depend on her own mother. Her memory was quite good and she was correctly orientated, but had difficulty in concentrating for any length of time. She was of average intelligence.

Progress. She had 6 E.C.T. following admission and became rather more depressed, and it is to be noted that at that time she was menstruating. Gradually after E.C.T. was discontinued and her period stopped she began to improve. Since then many of her problems have been discussed with her and she has gained ground steadily and had two or three successful week-ends at home. She is still in hospital at the time of writing.

Diagnosis. Depression following childbirth, and recurring following myomectomy in an insecure personality who had never been able to accept responsibility.

Case 3. R.W. Aged 37. Primipara. Admitted 20. 10. 49.
Home address - Middlesex.

Reason for Referral. Depression and inability to cope with household duties, starting five days after childbirth in May 1949.

Family History. The family were German Jews and the patient's childhood and adolescence were spent in Frankfurt where the father had a furniture business. He was a highly intelligent man, preoccupied with Bible and ancient history research, and philosophical problems. The patient was very much attached to him and was brought up to believe that intellectual pursuits were the only worth while things in life. He was an affectionate but rather detached father and died in 1919 of coronary thrombosis when the patient was 6. The mother was 47 when the patient was born, was much ashamed of becoming pregnant at such an advanced age and found it difficult to cope with a new baby at that time. The patient was the youngest of four siblings with twelve years between herself and her next sister. The mother was a business-like, houseproud, highly religious woman with rather a narrow outlook on life. She and the patient did not get on well together, until the patient was grown up and married herself. In the patient's younger days, ordinary childish naughtiness was regarded as something far more serious. Following her father's death the patient's second brother assumed the father's role and was extremely strict towards the patient, so that at no time was her home life happy as she was over-restricted by her

mother and later by her brother. The only other member of the family for whom she had any real affection was her sister. The sister had an unhappy marriage, and during the war she was sent to a concentration camp and was never heard of again. The mother was brought over to England in 1938 and lived with the patient, during which time the latter felt constrained to make up to her for being so difficult in childhood and was most upset when the mother died in 1941 following a series of strokes. There was no family history of mental disorder although the mother had never completely recovered from the father's death and was subsequently subject to mild depression.

Personal History. There was nothing abnormal in the patient's early development except that she would have violent temper tantrums when thwarted. She was an extremely good scholar, but rather lazy because she found lessons so easy. She had many friends and several "crushes" on other girls. During her last four years there she was something of a leader in discussion groups and was frequently in disgrace as the views she expressed were not in keeping with those of her extremely Nationalistic teacher. She was never any good at artistic things, being over-meticulous and detailed. She left school at 18 against the wishes of her mother who considered marriage the only proper career for a girl. She started to study medicine at Frankfurt University, at the same time attending extra lectures in philosophy and political economy. She enjoyed this life tremendously and felt extremely mature. After the first year she changed to Prague University, to be with a man to whom she had formed a close attachment in her first year, and whose period of study at Frankfurt was finished. He was ten years older than the patient, and very attached to his mother. During the year in Prague they lived together but things were not happy. He waited for a job which never came and meantime lived on the patient's allowance from home which both resented. In addition to this their sexual relations were not satisfactory, he being furtive in his attitude and yet anxious for people to know he was living with a woman. The relationship finally petered out and the patient returned to Germany. She met her husband in December 1932 and on the occasion of their first meeting he proposed to her, but she refused to take him seriously. He was a law student, 13 months older than the patient, the child of German-Jewish parents; an undemonstrative, rather hysterical mother to whom he was very attached, and a harsh, strict, father. He was born in England and was naturalised. His own personality was a generous and tolerant one superficially, but at base in fact rigid and obsessional. Three months after their meeting he was imprisoned for political reasons. The patient, who belonged to the same student political organisation, fled to Poland in March 1933 where she became dependent on her early lover, whose home was in

Poland. She saw him now in a different light, as in fact rather a weak character. In May 1933 her husband was released and came to Poland where they were married in July 1933, against the wishes of both their parents. Their relationship was primarily a comradeship and their marriage for the sole purpose of obtaining a British passport to enable her to leave Poland. They went to Paris in 1933, taking any jobs they could get, as domestic servants and so forth, and there they stayed for the next two years. Their hardships cemented their marriage and they decided not to dissolve it. Sexually they were well adjusted, and the patient felt able to play the roles of father and mother, sister and wife that her husband wanted of her because of his own unhappy background. In June 1935 they came to England, where the patient at first worked in a factory and rapidly learnt English. Then after a commercial course she took a clerical job which she kept until 1937 when the husband was able to provide for them both, and in May 1938 her mother came over. In August 1938 they tried to have a child unsuccessfully and although disappointed superficially in many ways the patient was relieved as the war started so soon afterwards, and in any case she did not really want a child. In November 1940 the husband went into the Forces and in May 1941 went abroad. During his absence the patient had various jobs as a costing clerk involving a lot of responsibility and travelling. In this work she was very happy, until November 1944 when she had to have a sympathectomy for Reynaud's disease. She should have had two operations, but refused one for her legs, as she feared that it might somehow paralyse them. She suffered much pain in her arms after the operation until May 1945 and seemed to have lost all sexual feeling. In spite of avoiding all attachments during her husband's absence she wanted to know if her fears regarding sexual desire were justified and 2 months before her husband's return in February 1946 she formed a liaison with a charming, intelligent, but irresponsible Irishman. He was 10 years older than herself, and she started to have intercourse with him. On her husband's return she told him and the two men discussed the matter in front of her. Her husband could see no reason why the patient could not continue on a friendly basis with the Irishman although failing to see what possible attraction such a personality could have for her. She was extremely guilty about it and in addition thought she was pregnant. Her husband wanted her to have the child, but she did not, ascribing her refusal to do so to fears that her child might have the same asocial trends as the father, and also that it was unfair to her husband. She went to a doctor who refused to

help her, but shortly afterwards her periods started again. After the husband's return the period of readjustment was extremely difficult, the patient resenting her loss of independence. In November 1946 they were both offered jobs with the War Crimes Commission as translators but it was decided that the husband would be better to stay in the steady job he had, and the patient went alone. The plan was that they should work hard and save all available money for 18 months and then settle down. She stayed in Nuremberg until August 1948, found the life suited her exactly and enjoyed a close intellectual liaison with two women friends. She was reluctant to return home and horrified when she became pregnant almost immediately afterwards. Her husband was anxious to have children but she was not. She was frightened of the idea of childbirth and if he wanted children would have preferred to adopt one. She also thought she was too old to have a child, but finally superficially accepted the pregnancy. She determined it should be a girl, and weigh exactly 5 lbs 8 ozs because she was afraid of a difficult labour.

Previous Personality. She had always been a driving, energetic, highly independent person, shrewd in money matters and very much a man's woman until her friendships in Nuremberg. Her interests were of an intellectual nature; music, literature and philosophy. She was untidy until she had a home of her own, and then became over-particular about dust and cleanliness and could not be persuaded to relax her standards. She would always be over-anxious about new work but once she had grasped it would become rapidly bored and seek further intellectual conquests. She was undemonstrative, but sensitive and rather jealous and would never forget an unkindness.

History of Present Illness. Although the pregnancy was unwanted she made meticulous plans for the child and seemed completely inflexible in her arrangements and unable to put first things first. The house had to be spotless and the nursery just so. She had more vomiting than normal in pregnancy and was extremely conscientious about doing relaxation exercises. Two months before term she had an ante-partum haemorrhage whilst doing spring cleaning. She was taken to hospital but wanted to return home soon afterwards to continue her work. She was persuaded to remain in hospital and a baby girl, weighing 5 lbs 8 ozs was born on 14. 5. 49, fourteen days premature. The patient was upset by the birth as she was left alone at the time of delivery, the labour only lasting five hours. Five days after the birth she became very

depressed because the baby was not feeding properly and was losing weight. She kept getting up at night to see if it had stopped breathing. When she returned home three weeks later she found everything too much for her and worried that she was not handling the child correctly. She lost her appetite which increased her fears of not being able to breast feed as she was particularly determined to do. She became unable to sleep and anything that changed her routine in the slightest upset her. She changed to being over-dependent on her husband, unable to make decisions and wept frequently. Her G.P. sent her to a nursing home where she improved somewhat and the baby was weaned in spite of her protests. She had no confidence in them, however, and left after nine days. Following that, she worried about the cleanliness of bottles and teats, about flies and germs. The teat had to produce the same number of drops per minute as the book said, or else it was no good. She would repeatedly have to count out the number of spoonfuls of milk to go in the bottle and could never do so correctly, gradually becoming more and more anxious and depressed as she tried. She spent hours keeping house and nappies spotless. Finally she was afraid to be left alone with the baby and suspected her husband did not care for the child. Gradually her depression increased, she lost weight, and was constantly anxious with ever growing obsessional routines.

State on Admission. Physically, there was nothing abnormal apart from poor circulation in hands and feet. Mentally, she was tense, anxious, depressed and unable to sleep. She kept reiterating what a stable personality she had always been before this and blamed herself for her inability to cope at home now, and for neglecting her husband in the past, thinking she had accepted all and given nothing. She was critical of ward arrangements and rather suspicious. She constantly felt compelled to remember small and unimportant details. She was correctly orientated and her memory was good, although efforts to concentrate increased her tension. She was above average intelligence.

Progress. With psychotherapy she began to improve gradually, and recounted various dreams related to aggression with anxiety towards her husband, and others of a homosexual nature. Since the latter have started she has tended to become more depressed again but her relapses are closely associated with menstruation. She talked frequently of her lack of motherliness and her fears for the future in bringing up her child. She requires it to be nothing short of perfect and at the same time regards it as a threat to her own intellectual drives. She is still under treatment at the time of writing.

Diagnosis. Depression with obsessional features occurring in the puerperium in a woman whose psychopathology is such as to make an adjustment to childbirth difficult.

Case No: 4. E.H. Aged 29. Primipara. Admitted 16.11.49
Home address - Chester.

Reason for Referral. Depression, anxiety, hypochondriasis and inability to cope with household duties starting about 3 weeks after the birth of a first child.

Family History. The father, a retired club steward, was usually a jovial personality but highly nervous since being shell-shocked in the first world war. The mother and he did not get on well together and there was constant friction between them, which resulted in an over-zealous avoidance, on the part of the patient, of rows up to the present day. The mother died of cancer of the rectum in October 1947, the patient nursing her through her last illness and being most upset by her death. The patient's feelings towards her mother were mixed ones, over-dependent on the one hand yet striving for independence on the other. As the patient was an only child her mother fussed over her excessively and irritated her by so doing. A maternal aunt has been "peculiar" since the she of twenty and is now sixty-three. Although she has never been hospitalised her behaviour appears to be that of a catatonic schizophrenic.

Personal History. The patient was always difficult with food in early childhood and bit her nails during her schooldays. She went to a Convent School although not a Roman Catholic, but left there when she was 10 as she was becoming very backward. At the County School she was mediocre, had to work very hard to keep up and was over-anxious about examinations. She was an extremely good child at school. She left when she was 16 and subsequently went to a commercial college for two years. She had four jobs thereafter and her work record was good, although with one employer she was very unhappy and reduced to tears by her on many occasions. Her periods started when she was 12 and were accepted normally; she had no associated psychic changes but they were irregular and accompanied by severe dysmenorrhoea. She had no formal sex instruction and gained her information from books; nor did she have any boy friends before she met her husband when she was 16. They were at school together and became engaged in 1940. The husband was 3 years older than the patient, a tolerant, happy-go-lucky man but said by the patient to be rather "highly-strung". He joined the Shell Co. as an accountant in 1938 and has remained with them since. In May 1941 they married. The husband had joined the Forces in 1939 and served in the Army until January 1946. He returned to the Shell Co. afterwards and in November 1947 was sent out to

Venezuela where the patient joined him after her mother's death. She was particularly pleased to go as she had always wanted to travel. Their marriage was a happy one, but neither wanted children. The patient's mother had always told her that having children "messed up one's inside" and when she was dying attributed her own illness to previous childbirth. Intercourse was not altogether satisfactory to the patient who frequently failed to reach orgasm, found her husband at times over-demanding sexually and was anxious about becoming pregnant. Her subsequent pregnancy was unwanted and she had great difficulty in accepting it. She felt if she did have a child she would prefer to have a boy, but having never been interested in children dreaded having to look after it. She was anxious too about having to go into the hospital to have the child as the local inhabitants considered the treatment there was bad, and the doctors spoke only Spanish, as the settlement was small and remote from any large town.

Previous Personality. She always had many friends and mixed easily with them. She preferred women's company on the whole to men's. She had always led an active life but her interests were all rather superficial, and confined entirely to tennis, swimming, travel and clothes. Normally she was cheerful and without mood swings or hypochondriasis, although an anxious personality and inclined to worry over trifles. She had always been very fussy and rather sensitive about her personal appearance, lip-sticks having to match absolutely exactly and so forth. In her house too she was excessively house-proud and would become fidgety if things were not exactly right. Normally she was confident and a capable manager but too much concerned with other people's opinion of her and socially extremely ambitious, liking always to conform to convention. Before doing anything she would give it most careful thought and make so many lists of things to do, or accounts of money spent, that it would drive her husband frantic.

History of Present Illness. Once having accepted the fact of her pregnancy she made perfectionist arrangements for the child in the way of clothes, and nursery. Throughout the pregnancy she worried that minor mishaps would injure the child, for example, she wept all night after a jeep in which they had driven home had gone over a bump, or because when they flew to Barbados for a holiday, she vomited all the time. The baby was 3 weeks overdue and when she was sent into hospital in labour the doctor could not be found. When he arrived he could speak no English and the nurse could speak no Spanish; he conveyed to her

that the baby wouldn't arrive for many hours and disappeared again. Ten minutes later the patient realised that the child was almost born and had to get another patient to find the nurse. The birth was rapid and the patient had bad cervical and peroneal tears. She had 11 internal and 6 external stitches and was extremely upset by this. The first night she was awakened by a native woman in labour in the next bed who was howling like an animal. She was not washed properly for two days and her stitches became infected. She worried constantly about the lack of sepsis and the filthy conditions of the lavatories, etc. The baby would not feed properly but she was told she could leave the hospital on the seventh day and there was nothing wrong with her stitches. The baby's cord did not slough and she had to attend the hospital every day for dressings. When she was discharged the hospital failed to let her husband know so that when he finally arrived and took her home nothing was prepared. The baby cried constantly, was never satisfied and the patient's milk left her. When she took him to the hospital she was given contrary instructions by nurses and doctors. She was unable to get the correct artificial milk for the baby and the only kind she could get had instructions written in Spanish only so that they were uncertain of quantities. Both the baby and the patient were losing weight steadily and the patient in addition was still losing blood; she became convinced that her "inside was messed up" and felt she looked like her mother just before she died. The hospital then cauterised her external stitches and because the baby's cord had not sloughed they cauterised this too, with much screaming on the part of the baby until the patient ultimately fainted. Following this she became unable to eat, lost all confidence in the doctors and all hope for the future. Every day she had to go to the hospital for liver injections or to have her stitch wounds attended to, often waiting for long periods before she was seen. By the 6th week the baby was very ill, not feeding properly and losing weight rapidly. Finally the husband took the patient and baby to Barbados where she was admitted to hospital. The doctor there criticised the treatment she had already had and suggested that the cervical laceration might lead to other things in later life, especially as she had had the wrong treatment. She worried then that she might develop cancer. She had a D & C and soon afterwards developed a bowel infection. The baby had bronchitis and again lost weight. Finally the physical states of both baby and patient began to pull up but her anxieties for them both, continued. She felt convinced the baby would never get better and worried about every trifle. She returned to Venezuela and arrangements were made for her return to England. She then became convinced that they would neither be allowed to leave Venezuela nor enter England. She feared that the passports were wrong and was anxious and indecisive. On arrival in Chester she became worse, wept constantly, was unable to concentrate or look after the baby, and

began to think people were against her and trying to get rid of her. She ate and slept little, complained that she could not think and blamed herself for letting her husband down. Even though her mother-in-law took charge of the child, who was now well, she continued to worry about him and felt sure he was not being properly looked after. She had increasing attacks of agitation with rapid talking and weeping and expressed vague suicidal ideas. She was seen by a psychiatrist in Chester and referred to the Out-patient Department of this hospital for psychotherapy, but was admitted as an emergency the same day.

State on Admission. Physically, there was no abnormality although she was thin and sallow with dark rings under her eyes. Mentally, she was tense, jumpy and talking rapidly. She could not make up her mind where to begin her long tale, but once started there was a steady stream of talk interspersed with nervous clearing of the throat and clicking of her fingers. She was extremely hypochondriacal, and discussed in detail her treatments whilst abroad and her fears for the baby although more so those for herself. She was predominantly depressed although able to smile in a quick, strained manner, and was unable to eat or sleep. She blamed herself for not returning to England to have the baby, and also for its unsettled start in life, and had fears that she would become mentally peculiar like her aunt. She felt she might not have broken down, had her arrangements for the baby not been so perfectionist. She complained of forgetfulness although her memory was quite good on testing. She was correctly orientated, but her concentration was poor, and the effort required increased her tension. She was above average intelligence but had little insight.

Progress. She remained in the same state for about 6 weeks following admission, but with discussion of her problems, encouragement to take part in all activities, and building up of her general health, she gradually began to improve. At the time of writing she is almost well again, and becoming more sure of her ultimate ability to cope with domestic duties although she still has doubts about doing her best for the baby because of her lack of motherliness.

Diagnosis. Agitated depression with hypochondriasis starting after the birth, under adverse circumstances, of an unwanted first child.

Case 5. J.S. Aged 29. Primipara. Admitted 27. 8. 49.
Home address - Lasswade, Scotland.

Reason for Referral. Tearful, excited state with insomnia, starting three days after childbirth on 21. 8. 49.

Family History. The patient herself was an illegitimate child adopted in babyhood by a nightwatchman and his wife. Nothing is known of the real parents but the adoptive parents were a kindly, stable enough couple, with five children of their own, the patient being the youngest member of the family. The patient was greatly attached to the adoptive mother, who was on the whole good to her, but inclined to emphasize the fact that she had been an expensive and difficult baby to rear, so that at times the patient had a tendency to feel that she was odd man out. She discovered her illegitimacy when she was 14 years old via other girls at school and was much upset by it. The adoptive mother died in 1939 when the patient was nineteen, and felt her death deeply. The religious and other standards in the family had always been rather strict, and became worse from the patient's point of view following the adoptive mother's death when one of the adoptive sisters, a widow who had been irritable and difficult for some years following a head injury, took over the running of the family. This sister always credited the patient with the worst motives, bullied her about the hours she kept and was generally very restrictive with her.

Personal History. During childhood the patient had various neurotic traits, talked in her sleep, kept a dummy until she was three, and was fussy about food beyond fourteen years of age. She did well at school but owing to minor ill-health left in the class below the top. She had many friends at school, but lost them after leaving as they were mostly allowed to go dancing, which was not approved of by the patient's parents. Her periods started at 14½ and following the adoptive mother's death she had a short period of amenorrhoea, otherwise there have been no psychic changes associated with menses although she has always been tired and lethargic at that time. She attended night school at her own wish to do arts and crafts for 5 years after leaving school, at the same time working in a paper mill during the day until 1942, when she left and joined the A.T.S. She found the job she was expected to do there too difficult for her, had a hysterical breakdown just before an examination, and was sent to St. Andrews, Northampton for 4-6 weeks. She was then, after five months in the service, invalided out. She returned to the paper mills and remained in that work for about 3½ years but became restless and dissatisfied. Subsequently she had numerous jobs as a children's nurse or domestic help, always leaving for inadequate reasons or being sacked. Her sexual information was gained in a casual manner from other girls, as the subject was never discussed at home, but until she was twenty-one the patient believed babies

came from the umbilicus. She met the father of the child when she was 17½ but they parted two years later on account of his jealousy. When she was twenty she became engaged to another man, a year younger than herself, but after two years he broke the engagement, giving no reason for doing so. Between the ages of twenty-seven and twenty-eight, she had a mild love affair with a commercial traveller a good deal older than herself, but meantime in 1948 again met her child's father. She started to have intercourse with him in August 1948 and she became pregnant in December 1948. Although previously having agreed to marry her should this happen, he now turned against her. In October 1948 she persuaded him to travel on the railway with no ticket and got him into trouble and on these grounds he left her. The father was the same age as the patient, an unstable individual who drank too much and was dominated by and over-attached to his mother, who refused to countenance their marriage. The patient refused to have an abortion performed at the suggestion of the child's father and he, in the face of several visits from the patient's family, finally denied paternity. In an attempt to avoid a scandal in the village the patient came to stay with friends in London until after the delivery.

Previous Personality. She was a happy-go-lucky, popular person, normally cheerful, but with a tendency to swings of mood, and became quickly depressed if she felt people disapproved of her. She was always full of energy, but rarely finished a job. She mixed easily and on the whole preferred men's company. She always wanted to be in the limelight, and was the "life and soul" of every party. In quarrels she frequently took the way of least resistance and much disliked violence, although she was often very argumentative. She was extremely fussy about her personal appearance, pressing her clothes after each wearing and insisting upon a place for everything. She was more interested in men's pursuits than in women's and took a keen interest in football.

History of Present Illness. The baby was born on 21. 8. 49 following a 5-hour labour. There was little anaesthesia as the patient was afraid to breathe the gas and air, and she sustained a fairly severe tear. There was some difficulty in placental separation and she lost 30 ozs of blood. On the third day of the puerperium there was a slight rise in temperature which settled in 24 hours. She was rather demanding from the time of delivery onwards and on 25. 8. 49 she became restless and over-active. She constantly wanted attention when the baby was being fed although she herself did not want to feed it, as she intended to return to work. She slept badly on the night of 25. 8. 49 and dreamt that little clots of blood were coming out of her mouth and that she was losing all her teeth; she also dreamt that she was chasing the electric trains which ran by the house. On 26. 8. 49 she cried when her friend didn't

come at once and thought she wanted to get rid of her, and on that night had an attack of screaming. She remained restless, over-excited, sleepless and had no interest in the baby. A domiciliary visit was paid and the patient admitted to hospital on 27. 8. 49.

Condition on Admission. Physically, she showed no abnormality. Her breasts were still slightly active and she had some reddish brown vaginal discharge. Mentally, an over-talkative woman, too anxious to please, and at times on over-friendly terms with the staff. She was excessively active, constantly moving about in bed, talking endlessly about the events which led up to her illness and every now and then weeping and blaming herself for her illegitimate pregnancy. Her orientation was correct and her memory good. There was heightened distractability but no true flight of ideas. General information and intelligence were average.

Progress. During the first week following admission the patient remained restless, over-active, constantly talking and at times tearful. Her lactation was stopped with Stilboestrol. When she got up a week later she still remained too active, organising other patients in a kindly way but to some extent interfering. She complained frequently of headaches, but these cleared up after a minor degree of anaemia which was present had been treated with Ferrous Sulphate. With supportive psychotherapy in relation to previous and possible future difficulties she settled down. The child was legally adopted by her friend, she was discharged recovered on 12. 10. 49, and returned to Lasswade a fortnight later. She was referred to a Welfare Agency in Edinburgh and a letter from her, a month later, indicated that she was settling down well.

Diagnosis. A mixed affective state occurring in the puerperium, in a basically unstable personality facing an illegitimate pregnancy.

Case 6. M.H. Aged 35. Primipara. Admitted 22.6.49.
Home address - South West London.

Reason for Referral. A re-admission for the gradual recurrence of depression and inability to cope with

household duties since April 1948, in a woman who had previously had a puerperal mental illness.

Family History. The patient's father died in 1939 at the age of 61. He was an accountant and although successful in his profession he was a disappointing husband and in spite of being particularly fond of the patient and she of him, an uncertain father with a capricious temper and sharp changes of mood. A nervous man, he had marked twitching of the face and fussy and exacting eating habits. Like his father before him, he drank heavily as indeed did most of his family. The mother was a cold, self-sufficient woman whose marital unhappiness was ill-concealed from the children. She never welcomed their birth although she preferred her sons to her one daughter. At the menopause the mother was depressed but was not hospitalised. The patient was the third of four siblings, the others all being boys, none of whom has subsequently achieved a satisfactory marriage with children. The patient held her own with her brothers and enjoyed playing boys' games but on the whole they were an undemonstrative family, chary of showing or even feeling affection. From the material aspect the home was adequate, the mother doing all the housekeeping and discouraging the patient from helping.

Personal History. The patient's early development was slow. She walked and talked late and had temper tantrums or sulked when thwarted. She also bit her nails in childhood. She was a mediocre pupil at school and left in a class below the top when she was 14. She was, however, good at games. She had a number of different jobs after leaving school, but showed no enthusiasm for any of them and usually left for inadequate reasons. Her periods started when she was sixteen and having had no instruction she was much upset by it. Subsequently she has always felt acutely embarrassed and irritable during menses and has suffered from menorrhagia. If crossed at these times she would scream herself into a hysterical tantrum. Sexual subjects were taboo at home and she subsequently always found difficulty in discussing them even with her husband or a doctor. She had a succession of boy friends, never stuck to any one for long, and was not attracted by the idea of marriage. She preferred men of other nationalities to her own and had friendships in turn with a Belgian, an Egyptian and a Spaniard. During an affair with the Egyptian in 1935 there was a party at which he threw a whisky bottle at her, she received severe lacerations of neck and head and was unconscious for five days and had transitory visual and speech defects. She recovered after six months but was thereafter extremely shy and self-conscious about the scars. She apparently delighted in playing one man off against another. Her parents disapproved of her

friendships with foreigners and there were frequently disturbing scenes in the home when she had been out late with one. After these scenes the patient would sulk for days. She eventually rather unwillingly accepted the idea of marriage to the Spaniard, probably more because her parents were strongly opposed to it, than for any other reason. She first met her husband, then a clerk at the Spanish Embassy, when she was nineteen, he being nine years older than herself. Early in 1937 the patient went to Spain, became a convert to Roman Catholicism and married in April, without any of her own people being present. Her husband was a stable, considerate, kindly man, but their marriage was not a success. Intercourse was never satisfactory to the patient and she frequently refused to have it. For two years the patient and her husband lived in hotels in Spain, then went to Italy, where they again moved from one hotel to another. They planned to have a child and although the patient was well during pregnancy, she felt somehow she would not possibly bear a child and intensely disliked the distortion of her body by pregnancy. The baby girl was born in April 1942 after an uneventful labour and the patient breast fed successfully for a week. At that time she suddenly became more and more antagonistic towards husband and child. She had episodes of acute excitement and weeping with suicidal ideas. She was with difficulty persuaded to continue breast feeding but at three weeks her milk failed. The acute stage of her illness lasted four weeks and then gradually subsided. After two months they moved to Spain to live with her husband's family and four months later the patient had completely recovered. In 1943 they returned to England, and from then until 1947 they lived in various hotels outside London to avoid the bombing. In March 1947 they had their first home but the patient disliked it from the beginning and was unable to look after it. She knew nothing of housekeeping, and cooking, and was unable to cope with her child's activities, never having had to manage alone before. She showed gradually increasing fatigue worry and resentment over housework and concern over the child's welfare. She became depressed and irritable, finally spending most of her time in bed complaining of various aches and pains, complete lassitude and inability to cope. She showed no interest in anything and had severe menorrhagia. She was admitted to hospital on 19. 5. 49 and diagnosed as "a depressive illness in an immature egocentric person showing obsessional traits". She had a number of hypochondriacal preoccupations regarding cancer, T.B., and insanity. She had 4 E.C.T. and gradually improved. Her husband was away in Spain at the time and on his return she became anxious and developed diarrhoea which continued for two weeks. She gradually recovered, became willing to face her duties and was discharged on 30. 9. 47. She was asked to attend the Follow-up Clinic but failed to do so.

Previous Personality. She was an aggressively independent person with only superficial friends. She was anxious, worrying, unsure of herself and very sensitive, yet egocentric and selfish. She tired easily and disliked the humdrum routine of a housewife's life, although on the other hand she had excessively high standards in her home and personal appearance. She could not bear anything to be dirty and was sensitive to her child's comparison of her home with those of her playmates. She was mildly hypochondriacal and preoccupied with worries about T.B. and cancer even when well. Usually she was unemotional and detached but when thwarted had paroxysms of temper. When she really wanted to do something she showed extreme determination in carrying it through.

History of Present Illness. This will be very brief as it does not pertain to childbirth. Following her discharge from hospital in September 1947 she remained well although dissatisfied with her flat. In April 1949 her brother was found to have T.B. and the patient's child also found to have a lesion, although it was quiescent. She became anxious and depressed and started to worry about the inconvenience of the flat again. She was restless and indecisive and took to her bed for a week. During May she had 'flu' and was ill in bed for a month and following this she lost her daily help. She began to get depressed again, was irritable and saw no point in living. She had to be washed, would hardly talk and had insomnia. She got steadily worse and in June was admitted to an observation ward where she improved and was subsequently transferred to this hospital.

Condition on Admission. Physically, there was no abnormality, apart from the old scars on neck and head about which she seemed unduly embarrassed. Mentally, the depression seemed to have cleared up, although she was still extremely tense and anxious. Her concentration was poor but memory, orientation and general information were all good. With discussion of her difficulties her condition rapidly cleared up and she decided to go on a holiday to Spain with her husband. She was discharged on 22. 7. 49, and asked to attend the Follow-up Clinic. When she was seen last in December she had got a new house and seemed settled and happy apart from worry and guilt towards her husband about her persistent frigidity for which she was anxious to have further treatment.

Diagnosis. Reactive depression and anxiety secondary to domestic difficulties in an unstable, immature personality who had previously had a breakdown in the puerperium.

Reason for Referral. Depression and strange behaviour starting three days after the birth of a first child on 10. 12. 46.

Family History. The father was a slater, now aged 50; a rather self-important man but quite a good father. The mother was a jolly, friendly woman devoted to her large family of children. The patient was fourth eldest of six siblings, all of whom were quite normal, healthy personalities, although the patient's younger sister was considered to be nervous. The household was an average working class one with a harmonious atmosphere and strong family ties. There was no family history of mental disorder.

Personal History. The patient's early development was normal, except that she, like her mother before her, bit her nails. She attended school till she was fourteen, was a good scholar and reached the top class. She had rheumatic fever at fifteen which left her with valvular disease of the heart. After leaving school she had two factory jobs in which she worked well up until the time of her pregnancy. Her periods started when she was fourteen, the onset was not traumatic and there have never been any associated psychic changes. Prior to her marriage she had two boy-friends, and finally met her husband in February 1945 while he was still in the Army. The husband was the same age as the patient, normally working in a satisfactorily paid clerical job, a stable, capable personality, but over-dependent on his own mother. They married in December 1945, the marriage was a happy one and sexually they were well adjusted. Following marriage they continued to live with the patient's parents owing to the housing shortage and the impossibility of getting a home of their own. In March 1946 as the patient's parents' house was rather over-crowded, and also because the patient's husband never seemed to feel completely at home there, it was decided that they should go and live with the parents-in-law. There they were given a room of their own in an eight-roomed house. The mother-in-law cooked for them, or if the patient did so, was extremely critical of her. The aged maternal grandfather, who also lived there was constantly interfering and altogether the patient became very unhappy under these adverse circumstances and was often reduced to tears. The mother-in-law was moody, short-tempered and domineering. About March 1946 the patient, who wanted a child, became pregnant. As the months passed the patient's relationship with her mother-in-law became worse although she tried to avoid rows at all cost and kept most of her unhappiness to herself. Her own parents and her in-laws could not get on and this too increased her distress.

Previous Personality. The patient was always a happy, sociable girl who went about smiling and got on well with everybody. She was of a peaceful, rather

sensitive disposition, avoided rows if at all possible, never complained, and although she was not shy she was liable to keep grievances to herself. She was not upset by the air raids in London throughout the war. She had many girl friends and enjoyed their company when she had leisure to spend, although during the war this was limited and she worked extremely hard with long hours in her job.

History of Present Illness. She was admitted to hospital a week before delivery and seemed quite well. On 9. 12. 46 she was delivered, without complications, of a healthy boy. About three days after the birth she seemed worried, especially about feeding the baby, cried frequently at night, and was slow in answering questions. The nurses were rather unsympathetic about her feeding worries and on one occasion, when the patient asked something, she was told that "as a mother she ought to know". Ten days after delivery she became strange in manner, thought she had done something wrong and did not seem to remember having had the baby. Three days later she was incontinent of faeces. Finally she became mute and was transferred to this hospital on 27. 12. 46.

State on Admission. Physically, she showed no abnormality except rheumatic valvular disease of the heart. Mentally, she was mute and resistive, doubly incontinent and could be spoon fed only with difficulty. She was apathetic but did not seem markedly depressed.

Progress. She remained mute and resistive for a month after admission. She was given intravenous sodium amytal, under which she expressed ideas of guilt and self-reproach, saying "they are all right really - his people - I thought I was upsetting everybody. They're waiting for me to die - my people - I was too pig-headed". After that she relapsed into a mute and resistant state again. She continued to be doubly incontinent, was agitated at night and by day in partial stupor with periods of activity and excitement. For a whole day she repeated "Could I?" and there was also perseveration of movement at times. For short periods she would weep, and at other times seemed perplexed or smiled in a rather fatuous manner. In May 1947 she was started on E.C.T., had three treatments and became progressively more cheerful, spontaneous, active and talkative. For the next three weeks she was mildly elated but gradually settled down and was discharged completely recovered on 31. 6. 47. A new flat had been found, to which the patient went on discharge. She was followed up for six months and had remained well up until that time, and able to cope with housework and baby.

Diagnosis. Mixed affective and schizophrenic disorder occurring in the puerperium, probably related to social difficulties at home and inconsiderate handling in the maternity hospital.

Case 8. J.W. Aged 28. Primipara. Admitted 7. 7. 48.
Home address - West London.

Reason for Referral. Depression and strange ideas starting sixteen days after childbirth on 6. 6. 48.

Family History. The father was a retired consulting engineer, a domineering man who ruled the home completely and ill-treated his wife emotionally, if not physically. He had had academic ambitions himself which were never realised and was over-exacting with his children in intellectual spheres. In his late 50s he became rather strange in his behaviour, dressing up in women's clothes at times and flirting with the maids. The mother died in 1947 of cancer. She was a kindly but snobbish woman who endured the difficulties with her husband only "for the sake of her children" who, nevertheless, were perfectly well aware of the parental differences. The patient was with her mother towards the end of the latter's illness and was extremely upset by her death. The patient was older than her two brothers and devoted to both. She was extremely attached to her father, apart from minor quarrels in adolescence regarding boy-friends, until in August 1947 there was a serious rift in their relationship when the younger brother married against the father's wishes, and was supported in his action by the patient. She was never very happy with her mother, whom she considered rather inadequate and intellectually her inferior. There was no family history of mental disorder, except in an uncle following a head injury.

Personal History. There was nothing abnormal to note in the patient's early development. She was always a highly imaginative and artistic child, indulging in games involving acting and make-believe. She was taught at home by a governess until she was eleven and then went to a school where the chief interests were art, drama, Greek dancing and the like. She passed her school certificate but was never brilliant. Her periods started when she was fifteen, and there were never any psychic changes associated. When she left school at seventeen she went to a school of dramatic art, where amongst other things she had a course of psychology. After three years training she took up teaching, and did well in the work until she left to get married. She had two or three boy-friends before marriage but none of a serious nature.

She met her husband when she was seventeen and they went out intermittently for three years when he went to India in the Army. During his absence they continued to correspond and on his return in 1945 they married. The husband was the same age as the patient, an Administrative Civil Servant, and the only child of a widowed mother who disapproved of the marriage. He was a stable personality, but a good deal more intelligent than the patient who throughout her marriage was acutely aware of this fact. Six weeks after marriage the husband returned to India and three months later the patient, for a short period, began to regret the hasty marriage. He returned in April 1946 and they settled down together easily. There remained the tendency throughout their marriage for the husband to "get down to her level" and teach her politics and other things that he felt were essential. She on the other hand tried to balance the intellectual discrepancies by her knowledge of artistic matters and psychology and expended a great deal of energy on the efficient running of her home. Sexually they were well adjusted and both anxious to have children. She became pregnant in January 1947 but had a spontaneous miscarriage in March 1947, was very upset about this, feeling that she had not efficiently carried out her side of the marriage. She became pregnant again in September 1947 and remained well throughout her pregnancy.

Previous Personality. She was always sensitive and shy on meeting new people, and tended to be self-conscious with strangers, but in spite of that had numerous friends. Her interests were mainly in the theatre and ballet, the latter interest stimulated by her father. From her mother she had acquired the tendency to be rather snobbish. In new situations she was always slow in making adjustments, and tended to depend on her husband to make decisions. She never worried about health until her mother died of cancer and then at times she entertained occasional thoughts that she too might develop it. She took a great pride in her economical housekeeping.

History of Present Illness. A baby boy was born on 6. 6. 49. after a straightforward labour and delivery. Two days after the birth it was noticed that the child had a congenital defect of one eye with marked scarring of the cornea. It was seen by a specialist who said that nothing could be done for it. The patient became very upset and cried frequently about it. She was discharged from hospital a fortnight after delivery and although not appearing depressed then, she was unable to cope with the household duties. She breast fed the child but it lost weight, and she was much upset when relations remarked upon his small size. A week later she became strange in her behaviour, repeatedly asking it it was not time to feed the baby, just after having

done so, and started doing character analyses. The next day she rang up her husband to say that the servants in her old home were stealing and father was oogling the maids, and asked him to send for the police. Her husband returned home and the patient insisted upon analysing each of them and their "relative contributions of brain" towards the marriage. She drew diagrams showing them as being equal in a number of things, but brain and experience which she called male, much outweighed art and intuition which she labelled as female. She considered that her breakdown was due to an Oedipus situation between her father, herself and her husband, or alternatively between her mother-in-law, her husband and herself, also to the child's eye defect and to the death of her mother. She was unable to sleep that night and the next day was admitted to an observation ward. Whilst there she felt she was able to cure other patients and misidentified nurses as those from the maternity hospital. She lost interest in her husband and baby and thought she was going to die. She was later transferred to this hospital.

State on Admission. Physically, there was no abnormality. Mentally, she varied from restlessness and tears to immobility or the adoption of strange attitudes which she considered were Yogi male and female signs and could influence other patients. Her talk was circumstantial and diffuse with evidence of a thought disorder and autochthonous ideas. She was correctly orientated; her memory was good and she seemed to be above average intelligence.

Progress. During the period after admission many of her delusions centred round eyes and she felt they were the key to her whole illness. Even her ideas about Yogi worked back to that, in the following way. Her uncle had his head injury over the occipital lobes, which she knew to be connected with sight, and that uncle came from New Zealand which she associated with Maoris and thought that they knew something about Yogi. She also felt that she must not look at people or their eyes would become damaged. She felt that doctors were hypnotising her and that this also was something to do with eyes and that if she "used her eyes positively" she could pick up clues that the doctors strewed about for her benefit. She said that when she was told about the baby's eye at the maternity hospital, they had hypnotised her while they told her, to lessen the shock, and thought that as a result of this she herself had gained psychic powers. She felt that her own eyesight

was splitting up into rays and that things had "crossed over" in her brain. As a result of her husband trying to improve her intellectually, she felt she had absorbed all his brain and that by losing grip of her own mind in illness she was losing, as well, what he had given her, in the form of marriage and happiness. She felt she could read her husband's thoughts and that she was overwhelmed by the strength of his personality. She talked of being at the centre point of a see-saw but felt, to keep a correct balance, one had to give and take. Gradually her delusional ideas began to fade and eighteen days after admission she appeared normal. She maintained her improvement and was discharged on 20. 8. 48. She has subsequently been followed up for one year and there has been no evidence of a relapse.

Diagnosis. An acute schizophrenic illness with depressive features occurring after the birth of a child with a congenital eye defect.

Case 9. M.D.H. Aged 31. Primipara. Admitted 28.6. 49.
Home address - South East London.

Reason for Referral. Peculiar behaviour starting twelve days after childbirth on 20. 5. 49.

Family History. The father was a masseur, with rather a rigid personality and had no great attachment to the patient. He had been married previously and died when he was seventy, in June 1948, from cancer of the mouth. The mother was a kindly woman to whom the patient was greatly attached and her death at forty-four, also from cancer, was a great blow to the patient who was fourteen years old at the time. After her death the patient, with her brother and sister, were looked after by the step-sister (the child of the father's first marriage), but was not altogether happy and was inadequately fed. There was no history of mental illness in the family.

Personal History. The patient was a normal, healthy child, who did very well at school, had many friends, was happy there and won a scholarship to High School which she left when she was seventeen years old. Her menarche was at eleven years, she was not disturbed by it and subsequently had no psychic changes during menses. She had no formal sex instruction, but

picked up information at school, from other girls. She became a teleprinting operator after leaving school and remained in that work until her marriage in 1942. She met her husband, who was her first boy-friend, when she was eighteen and a year later went to live with his mother owing to the unsatisfactory conditions with the step-sister. She was happy at her future mother-in-law's and felt her to be a substitute for her own mother. The patient and her husband became engaged when she was twenty-one and there seems to have been no pressure put upon her by the mother-in-law. Her husband was always a mother's boy, possibly because he had been a "weakly child" requiring much maternal care, but in adult life he appears to have been a stable, cheerful fellow, a year older than the patient, employed as a House Manager by Vogue Magazine and earning a good wage. Shortly after marriage the patient went to Scotland to join her husband who was then in the R.N.V.R. and stationed there. She stayed for six months and did part-time work in a munitions factory until her husband went abroad in 1943. She then went into Cable and Wireless Ltd., as a telegraphist. She stayed there till 1946 when her husband was demobbed and then stopped working at his suggestion. At that time they moved into the top flat of the mother-in-law's house. The marriage was a happy one and intercourse satisfactory to both. They discussed the question of having a child, both wanted one, and they then gave up using contraception and the patient became pregnant soon afterwards. She was very happy about it, planned to have two children and wanted the first one to be a girl. Two or three times during pregnancy the baby had to be "turned" but was eventually a vertex delivery. Labour was rather severe, lasting twenty-four hours but was normal apart from a tear and the baby, a girl, was born on 20. 5. 49.

Previous Personality. The patient was never very demonstrative and was rather sensitive and at times self-conscious, although she and her husband belonged to a camping club and had various friends in connection with this activity. The patient never had any really intimate friends although she was closely attached to her younger sister, whom she saw every week. She got on well with people and although not a leader, had a will of her own and could stand up for her rights. She was an efficient housekeeper and the house was always kept like a "new pin". Her prevailing mood was one of cheerful serenity and she always had "a smile for everyone".

History of Present Illness. At first following delivery she seemed to be normal in spirits except that she was somewhat worried because the baby did not take to the breast properly and had to be put on a bottle. Ten days after delivery the hospital

reported that she was behaving strangely, laughing and weeping for no reason. On 2. 6. 49 she was seen by a psychiatrist who noted thought blocking, silly incongruous smiling, and retardation. She told him that she owned the hospital. She was transferred to an observation ward on 7. 6. 49, where she was almost mute, showed no signs of emotion or interest in anything, and finally became restless, resistive and difficult with food.

State on Admission. Physically, there was no abnormality. She appeared a well nourished, rather hirsute woman. Mentally, she was almost completely mute and grossly retarded. She responded to requests but for the most part lay in bed, not moving with a faint smile playing round her lips which at times almost became laughter. At this time there was no evidence of depression. She had to be spoon-fed and on one occasion was incontinent of urine. She appeared at times to be auditorily hallucinated.

Progress. Following admission the patient became completely mute, but able to respond to jokes by laughing and smiling. The evidence of auditory hallucinations became more definite. She responded to requests, but gradually became resistive about food. About a week after admission, she was given intravenous sodium amytal during which she talked freely and showed evidence of a schizophrenic thought disorder. She said she felt like a dicky-bird because she had two eyes and a third one on top of her head and suggested that it was because this was St. Francis Hospital (the name of the observation ward where she had been prior to admission). She stated that when she looked at people they seemed to change in some way and she had little knowledge of where she was. She seemed disinterested in the baby's welfare or whereabouts. Gradually she became rather manneristic, grimacing, blinking or lying with eyes closed. A course of E.C.T. was started and she began to improve, but had little memory for having had a baby or other events preceding coming into hospital. She seemed mildly aggressive and perplexed with rather inadequate affect. After a course of 6 E.C.T. she appeared completely well again and was given a week-end at home. During that week-end she began to relapse and although she did not become completely mute, she was more withdrawn and solitary with incongruous affect, ideas of influence and again a schizophrenic thought disorder. Throughout August she became more childish, negativistic in manner, and often not speaking in more than a whisper. There was at this time evidence of slight depression. She denied having had a baby and also that her husband was in fact her husband. At another time she stated she

had one child and was pregnant with another, then rapidly denied this latter pregnancy was her child but belonged to one of the nurses. Insulin treatment was started on 30. 9. 49 and E.C.T. was given in sopor. She gradually improved and had a total of 32 comas. Thereafter she improved rapidly and had fairly good insight into her illness, but there was still some evidence of flattening of affect. She had several more successful week-ends at home and was discharged on 2. 12. 49. She has been attending the Follow-up Clinic since discharge and her condition appears satisfactory although she is rather "stolid" and flat in her affect.

Diagnosis. This appears to have been an acute schizophrenic episode occurring in the puerperium, with at times evidence of affective features.

Case 10. B.E. Aged 29. Primipara. Admitted 5. 7. 49.
Home address - North London.

Reason for Referral. Depression and strange behaviour starting four days after childbirth on 24. 4. 49.

Family History. The family was a Jewish one. The father, a man of 65, was a retired greengrocer who in his early days had been forced through poverty to sell fruit on the streets. He was a good father and a hard-working, rather quiet man, who suffered from diabetes. The mother, a woman of 61, was the central figure in the family, a rather talkative, overbearing personality who had always ruled the family with a rod of iron, and worked extremely hard in the early days of difficult financial circumstances. The patient was the sixth and most reserved of nine siblings, all of whom were stable except the youngest brother who was treated at this hospital for a schizophrenic breakdown. The patient's early home life was a happy one in which the parents got on well together and the family was a closely knit unit. There was no other family history of mental disorder.

Personal History. The early life of the patient was normal except that as a child she was afraid of the dark or of being left alone. At the age of three she had measles very badly and subsequently developed a severe myopia which was attributed to this illness. She went to a myopic school until she was 14 but was never a good scholar, was always rather diffident and had few friends. She became deaf at the age of eight following an adenoid and tonsil operation. Her periods started when she was twelve and were regular, accepted normally, and never associated with any psychic disturbance. After leaving school she went into a millinery business run by her sister in London. In 1941 the whole family moved to Luton on account of

the bombing and the sister opened a millinery business there in which the patient continued to work. In 1944 the mother returned to London but the patient remained in Luton until the time of her marriage, living and working with her sister and visiting her mother every week-end. She started going out with boy-friends when she was eighteen and enjoyed it but never had much to say for herself. She was introduced to her husband by friends of her parents when she was twenty-six. For six months they went out together and the marriage was finally arranged by the two families, the patient's mother buying the engagement ring because the husband was too busy. In January 1947, about the time of her engagement, the home was robbed of some jewellery and the patient became depressed and worried that her mother had not told her husband that she was deaf. Finally she became completely mute. She was seen by a psychiatrist at that time but her illness cleared up two weeks later and she appeared quite normal again and was married in September 1947. Her husband was seven years older than herself, owned a furriers business and was a quiet man but rather sarcastic. This latter feature of his personality has tended to make the patient mildly unhappy at times, especially when his sarcasm was directed at her physical disabilities. Apart from that the marriage was happy and intercourse satisfactory to the patient. The husband was anxious to have children and the patient accepted it quite willingly as a part of her married life. For a year they tried to have a child before the patient finally conceived about the time of their first wedding anniversary in September 1948. Although she was unaware that she was pregnant she had a further breakdown similar in character to the first except that this time she worried that her husband was supposed to have only one testicle and feared that he might be sterile. She again recovered in two to three weeks.

Previous Personality. She was predominantly rather shy and diffident with strangers and quieter than the other members of her family. She had always been extremely neat in her personal appearance, tidy in her house and disturbed by things being out of place. She was energetic and did welfare work during the war. She remained afraid of being alone all her life and was in the habit of staying with her sister until her husband got in from work at night. She was always very sensitive and rather submissive, inclined to stint herself of food to provide adequately for her husband. Trifles tended to worry her.

History of Present Illness. Her pregnancy was normal until in the later months she developed toxemia with swollen ankles and high blood pressure, causing her

to be admitted to hospital and induced three weeks before term. The birth, however, was quite straightforward and a girl was born on 24. 4. 49. She seemed well for the first four days afterwards but then became depressed, refused food and feared that her baby might get mixed with other people's. Twelve days later she returned home, remained quiet and difficult with food for a further three days and then became normal again. Owing to this disturbance she had returned to her mother in London following her discharge from hospital and there she remained for three weeks during which time her youngest brother developed a schizophrenic illness. He was admitted to hospital and the patient returned to her husband in Luton. Whilst there she was well for a week but during the second week she began to worry about the baby again and kept getting up at night to attend to it. She began to eat and sleep badly, was very depressed and finally refused to sit still and kept rushing about doing things. Her husband sent her back to her mother's where she remained tearful, took no interest in the baby and for two days was difficult about passing urine. At night she behaved in a strange way, after going to bed, and would swing her legs over her head, then get out of bed, lie underneath for a little, and again return to bed. During the day she began to climb on the back of furniture or hide behind things. This behaviour changed and for about two days she would mimic people. When this stopped she became completely mute and then finally recovered on 1. 7. 49, being more or less amnesic for her previous behaviour. She was seen on a domiciliary visit and admission to hospital arranged.

State on Admission. Physically, there was nothing abnormal to note, apart from her deafness and myopia. Mentally, no abnormality could be detected and although co-operative and friendly she was naturally enough reluctant to enter hospital and leave the baby.

Progress. She remained perfectly well for about ten days and then seemed a little depressed and said she was not very happy because she was unable to see the baby. Arrangements were made for her to go home for the weekend but she returned markedly depressed and very retarded. She entered her room and immediately looked under the bed but gave no reason for doing so. By the

next day she was resistive and mute except for a few whispered remarks. She appeared bewildered and puzzled in manner the next day and resisted attempts to bring her in from the garden, placing her finger on her lips afterwards as though demanding silence. She remained mute and on one occasion incontinent of urine until about 27. 4. 49 when there appeared to be slight improvement and she began to take food and fluids more willingly. Although she would not speak when questioned, she would utter whispered spontaneous remarks which expressed her bewilderment at what was happening. She relapsed into mutism the following day and was given intravenous sodium amytal. Under this she said at first that she was blind, then asked what she had done wrong, and said that she had only wanted to go back to the baby and had been upset by having to return to hospital after her week-end at home. By 26. 7. 49 although still mute she started to feed herself on sandwiches brought in by her family, although still refusing hospital food. At times she appeared to be lying in bed and praying and later said she thought the food and drink given her tasted strange. During the next fortnight she gradually recovered, passing through a phase of talking very little only shrugging shoulders in answer to questions or speaking in a whisper. She had quite recovered by 10. 8. 49. and would remember only that she had felt miserable and had a strange fear of something unknown during her illness. She was given a week-end pass on 1. 9. 49 and returned on 5. 9. 49 again having started to relapse. The only possible precipitating factor during the week-end was a minor argument with her husband about getting a flat in London. She started to menstruate a few days after this attack had started and on further enquiry it was found that this had happened with the two previous attacks. She repeated the same sort of pattern as in the last attack except that there was more evidence of depression and at other times incongruous smiling than had been noted before. By 26. 9. 49 she had recovered. On 22. 10. 49 she again started to menstruate and relapsed at the same time. She showed the same pattern as on the previous occasion except that there was rather more bizarre behaviour and she was incontinent of faeces on one occasion and smeared them about the room. She was given 2 mgm of Lutocylin on 2. 11. 49 and 4. 11. 49. and the attack terminated on 9. 11. 49. She started to menstruate on 3. 12. 49. but did not begin to relapse again till 8. 12. 49 and the onset was much slower. She was given 5 mgms of Lutocylin on 14. 12. 49 and 16.12.49 and the attack terminated on 1. 1. 50. She menstruated again on 23. 1. 50, and on 3. 2. 50, 5. 2. 50 and 8. 2. 50 had a further 5 mgms of Lutocylin but at the time of writing (21. 2. 50) there has been no further relapse.

Diagnosis. Catatonic schizophrenia occurring on two occasions before childbirth and reappearing with increased frequency and greater periodicity following childbirth.

Case 11. M.J.C. Aged 20. Primipara. Admitted 25. 11. 49. Home address - South West London.

Reason for Referral. Excitement and strange behaviour starting nine days after childbirth.

Family History. The father, a man of 45, an electrical engineer, was always rather a morose personality. In the earlier days he owned a hatter's business which went bankrupt and from then on his wife starting nagging at him and there were constant rows. There was a close bond between the patient and her father, although as she grew up, she gradually began to despise him rather for not standing up to her mother. The mother, who was three years older than the father, was an over-emotional, excitable, hypochondriacal woman, with whom the patient had frequent battles. The mother was always very restrictive towards the patient, denying her things unnecessarily, and treating her like a child even when she had grown up. There were no other children. There is a family history of mental disorder, one aunt being in a mental hospital and a paternal cousin who has always been considered peculiar. The maternal grandmother and several other members of the family have had T.B. The patient's home life was never a happy one as apart from restricting her, the mother never had very much affection for the patient and as she grew up was in the habit of nagging and dictating to her.

Personal History. The patient had habit vomiting from birth until five months, sucked her thumb until she was a year old, bit her nails until she was sixteen, walked in her sleep and had a frequently recurring nightmare in which her fingers seemed to be swelling. She was never a demonstrative child, always seeming distant and shy, and had few friends. She had a rich fantasy life as a child, making up stories and music for a puppet theatre which her father made for her. She seemed to live in a world of her own, was slow in washing and dressing, forgot things she was sent for and appeared to be rather absent-minded until thwarted and then would have violent tempers. When she was ten, she was evacuated and remained away for four years, during which time the mother hardly ever visited her. In all she was in six different places, never settling well in any of them, often unhappy and in trouble for being wild and destructive and occasionally stealing small sums of money. Finally she was taken in by a Roman Catholic family and although the patient's parents were non-practising Roman Catholics, the patient became more

settled there and for a time became a regular attender at Mass and derived a lot of pleasure from the ritual. Her periods started when she was 12 and although she had been instructed and it was not a traumatic event, she was always very depressed during her menses. Whilst she was evacuated she used to get mixed up with soldiers and when she was about fourteen she had intercourse with one particular one. She was always very "highly sexed" and derived pleasure from intercourse. She did very well at school, was outstanding at languages, passed her matriculation with ease, but was rather lazy and left school when she was sixteen. After leaving school she studied Spanish, French, shorthand and typing at the Institute Francaise for a year and then got a job as a Secretary to Continental Laboratories. Whilst there she saw medical journals and took a great interest in what was written about childbirth. She stopped work about a month before marriage. She first met her husband in 1946 and started to have intercourse with him a year later. It would in fact have started sooner but for the fact that the husband was too inexperienced and shy to buy contraceptives. They became engaged in July 1947 in spite of a great deal of opposition from her mother. When marriage was suggested the mother became even more firm in her opposition, the matter was taken to Court and settled in the mother's favour. The patient and her husband then started to make plans for living together and finally by persuasion from his parents the patient's mother eventually gave her consent, and they were married in December 1948. Although the patient was anxious to have children they planned to avoid having them to begin with, but the patient became pregnant in February 1949. In many ways the marriage has been difficult. The husband was four years older than the patient, a student of music living on a grant after coming out of the services; sexually they have been maladjusted, the husband often not wanting intercourse when the patient did and at other times not able to satisfy her, with the result that she masturbated frequently but apparently without guilt. Her husband was a vegetarian and she was completely intolerant of this and many other of his opinions which differed from hers, so that at times there were very violent scenes in which the patient would throw things about and bang doors. They lived in an inconvenient top floor flat with two rooms. The landlady threatened to put them out when she knew the patient was pregnant and they were unable to find anywhere else to live.

Previous Personality. She always preferred men's company and herself wanted to be a boy, yet in her younger days she was extremely neat and tidy, repeatedly washing things and altogether "too fussy for a young girl". She was always rather reserved and shy even in adult life and disliked meeting new people. She tended to depend on her husband over-much in spite of being dictatorial at times. She had read widely and was

interested in philosophy, poetry and psychology, and took an active part in debates. Predominantly pessimistic, she was mercurial in mood and violent when thwarted. She was tremendously fussy about house and personal appearance after marriage and was much upset by dirt and disorder, often finding it difficult to get through her housework because of her high standards. Always rather self-conscious she has tended to depreciate her face and figure. She would cling on to old clothes indefinitely until forced to throw them away by her husband. She was extremely obstinate at times.

History of Present Illness. She had periods of depression throughout her pregnancy which became more marked when she failed to go into labour on the expected date. She went into hospital for four days at the expected time of delivery and was upset by another patient groaning and screaming in the same ward. She was sent home again after being told that she had a "high head". They also asked her to be examined for an M.D. examination and she felt she must be a rare case. She went into labour at home and in the ambulance was shivering, apparently nervous, and blamed herself for making the ambulance men have to take her into hospital twice. She was over-active and anxious in labour and sustained internal and external tears, when the baby was born too rapidly on 10. 11. 49. She had considerable haemorrhage after the birth and was anxious because the baby was not brought to her till some time after the birth and she had heard the doctors saying that he wasn't breathing properly and was being given oxygen. She was able to breast feed and things went smoothly after that until nine days after childbirth when she told her husband she was going to write a book or take a Ph.D., that she understood the universe and was now thoroughly integrated. The day following she still seemed over-talkative and anxious to explain the philosophical problems, which she now understood. She was discharged from hospital on 22. 11. 49 by which time she seemed depressed and disinterested in things and hardly answered when spoken to. On returning home she became very excited again, said that they were perfect parents and had the perfect child, that she knew instinctively when there was anything wrong with the baby and that it didn't require regular feeding. She left it eight hours, then thought the baby was dying, and wept all the time she was feeding it. She wouldn't eat, talked incessantly, saying she had been mentally defective all her life, but now wanted to meet the "clever brains" of the world and would not be shy any more. In the middle of the night she said she was causing her husband worry, that they must have a nurse as she was not confident to feed the baby, asked him to bring it at feeding times as she herself had no conception of time, seemed muddled, insisted upon 'phoning the maternity hospital but could not remember the number. She was

seen at the hospital next day and the following night kept ringing the alarm clock and telling her husband to wake up. She was seen again at hospital the next day, where she said she had a new theory of time, that she was part of a triangle that was not equilateral, her husband, baby and herself at each corner, there was a figure 3 alongside it, and a shamrock, and associated this with St. Francis, then corrected herself to St. Patrick. In spite of this she said she had had a period of insanity and was now recovering. The next night she became afraid the baby was ill, talked all night but was becoming difficult to follow. Next day she was seen by a psychiatrist, but prior to that complained that her fingers were swelling and that she must allow them to subside naturally in order to dispel her old dream by psychological means. She sat for an hour and a half waiting for this to happen with her hands held out before her. She told her husband she had become aware of every organ in her body, including her vagina, which she said had become insensitive through using Tampax. When seen by the psychiatrist on 25.11.49 she showed thought blocking, ideas of influence, variable orientation, said she knew God's plan but was unable to explain it and seemed calm and detached. She was admitted to hospital the same day.

State on Admission. Physically, there was no abnormality except for extreme engorgement of the breasts and a slightly brown vaginal discharge, but within twenty four hours of admission she had a sharp rise in temperature for which no cause could be found and which settled rapidly with Penicillin. Mentally, she complained of being unable to think, was confused, disjointed, at times wept and at other times giggled in a silly manner. She was disorientated.

Progress. As her temperature settled she remained confused and disjointed in her talk, said that her baby was Jesus Christ, repeatedly crossed herself, or at other times maintained that she had not yet had the baby. Sometimes she would scream out and seemed to be re-enacting the labour and would keep spitting out saliva. She was hallucinated and became very agitated at times in response to voices. When she was well enough to get up she remained silly, giggling and manneristic in her behaviour, said that she thought she was a man again that the flower vases in the room confused her and that she knew she had to be born again. She seemed preoccupied with urination, insisted upon pulling up her skirt before she would sit down on a chair saying that she had to do so because she was a woman. She started menstruating during the acute stage of her illness and refused to wear a sanitary towel. When her husband visited her she insisted upon undressing herself. She continued in this state for thirty-nine days and then gradually started to recover and at the time of writing is apparently almost completely well.

Diagnosis. Acute schizophrenic episode following the birth of a first child in an immature personality.

Case 12. M.C. Aged 35. Multipara. Admitted 1. 11. 49.
Home address - South East London.

Reason for Referral. Depression starting four days after birth of her second child on 28. 6. 49.

Family History. The patient's father was a publican, who drank rather heavily himself, and was a forceful personality. The patient was his favourite child, and was very attached to him and much upset by his death in 1925 from a stroke. He had been bedridden for three years previous but it was nevertheless a considerable shock to her. Her mother kept on the business after the father's death. She was a capable, business woman, and a domineering personality. The patient was very fond of her but irritated by her domination. Two years after the father's death the mother married again and seemed more remote to the patient than ever, particularly when the marriage did not turn out well. The patient was the middle sibling of three girls and was very jealous of the younger one when the latter was a baby. She always felt odd man out and different from the others. The home life was never a happy one as the mother and father were always quarrelling and trying to persuade the children to side with one of them. Later the rows between the stepfather and the mother were even worse. The patient never liked him and took her mother's part in the rows which were often very violent. There was no family history of mental disorder.

Personal History. As a child the patient was always nervous, used to walk and talk in her sleep, and was afraid of people in authority. The sisters were all sent to boarding school together and the mother was too busy to take an interest in them. The patient was seven when she first went to school. As they got older they were moved to a Convent School, and here the patient used to feel very 'shut-up'. The pub never played much part in their lives except as a reason for not seeing much of their parents and realising that their father drank too much, and in a way they felt rather ashamed of their background. She was never a very good scholar and failed her matriculation. Her periods started at fourteen and their onset was traumatic to her as she had had no instruction. She left school when she was sixteen and went to a Commercial College and thereafter got a job as a secretary but was discharged for inefficiency after a few weeks. She then went into the pub to be taught the job by her mother. During the years which followed the patient found her job tiring and the endless brawling between her mother and stepfather very upsetting. She met her husband when she was

seventeen, but subsequently had two other boy-friends as well. Her husband was eight years older than herself, a book-keeper in a garage, and more attached to the patient than she to him. The patient's mother did not like him particularly as he was often out of work and was not a very stable personality. After they had known each other for some years they started to have intercourse and the patient eventually became pregnant. She persuaded a doctor to terminate the pregnancy but developed septicæmia. While she was recovering they became engaged in July 1937. Three months later they married and lived at the pub although the husband kept on his book-keeping job. In 1938 they took over the pub, the husband giving up his own job and the mother going off to join the stepfather who had left some time previously following a row with her. In February 1939 the patient had her first child. She did not want children very much and had never been interested in them, but accepted the pregnancy. She breast fed her child for three months but lost her milk and the child was weaned. The patient was pleased about this because feeding interfered with the hours of the pub. She had great difficulty in bringing the child up and in fact her sister, who was a trained children's nurse, took over the job until the baby was eighteen months old. The patient never seemed to have any motherly feelings, did not know the right things to do and became anxious about even having to take her out in the pram. In the Autumn of 1940 the patient again became pregnant but managed to terminate the pregnancy. In November 1940 her husband was called up and during the next five years remained in this country so that they were able to see each other frequently. In 1941 the patient had pneumonia very badly and in 1942 she had another self-induced miscarriage. Between 1943-44 the patient had an affair with a married man which resulted in intercourse on two or three occasions and about which the patient felt very guilty. She became extremely depressed and went down to Cornwall to join her husband who was stationed there. She remained depressed for three months, afraid to go into shops and frequently crying in the street, but by August 1944 had recovered completely. In November 1945 the husband was demobbed and returned to work in the pub which the patient's mother meantime had taken over again. The mother had promised to retire when the husband returned, but failed to do so, and an atmosphere of unhappiness and uneasiness gradually grew up in the pub where they all lived. The patient and her husband felt neither servants nor owners and the husband started to drink too much. The patient was unable to get a separate room for her daughter, or a place for her to play, and was worried because the child had to witness many scenes between the mother and the stepfather. In addition the mother was so domineering that it became fruitless for the patient or her husband ever to make any decisions as they were always counter-

manded. In the next two years the patient became more indecisive and less cheerful than was her wont, and in September 1948 she became pregnant again. The mother advised her to terminate the pregnancy, but although she did not want a child any more than she ever had, in a spirit of rebellion she determined to have the child. During her pregnancy the patient's husband managed to get a flat but they kept it a secret from the mother whom they thought might object. The patient felt a considerable amount of guilt in relation to this and was very ambivalent in her attitude towards moving, having lived in the pub with her mother all her life. A baby boy was born on 28. 6. 49 after a straightforward labour and delivery.

Previous Personality. Although always very popular, she was a shy and retiring person, very submissive and with little self-confidence. Normally she was cheerful, vivacious and without mood swings, but had few interests outside the pub. She was very sensitive, easily hurt, would cry easily and be unable to hide her real feelings. Socially she had always been ambitious and had the "greatest possible aversion" to going down the social scale. Although energetic she tired easily. She was always fussy about her personal appearance and to a certain extent about her house and was the sort of person who would be able to let things get chaotic and then have tremendous bursts of tidying.

History of Present Illness. Four days after the birth of the child the patient began to get depressed and wept frequently. Her depression was increased by her inability to feed the baby owing to an inverted nipple. She stayed with friends for ten days after leaving hospital and complained of feeling "shut in" and as if she had "blinkers" on whilst she was there. Shortly after that they moved into their new flat, and the patient became more worried still because of the break from her mother and also because the flat had stairs and was not a cheerful or easy place to run. She became steadily more depressed, weeping frequently and ineffectual in managing her house and feeling she did not know what to do for the baby owing to her lack of motherliness. The G.P. recommended a holiday and the baby was put into a nursery for fourteen days, but on her return the patient was no better. The G.P. gave her three injections of Oestroform in September and October and following that her depression seemed to clear a little. She soon started slipping back again, however, got more depressed and said she couldn't look after the baby or the flat and three weeks before admission she attempted suicide by climbing out of a top-storey window. A week before admission she walked out of the flat leaving everything and went to her sister. She had not been sleeping for some time and

in addition would start drinking when she was alone. She was referred to the Out-patient Department and was admitted to hospital as an urgent case the same day.

Condition on Admission. Physically, there was no abnormality. Mentally, she was tense, anxious and depressed. She appeared retarded, was unable to make decisions or concentrate, and was afraid she would do the wrong thing. She was full of self-reproachful ideas and constantly went back over her past, arriving at the conclusion that she had "all the faults on earth". She worried that with smoking so much the nicotine would harm her stomach and felt she had done wrong in having the baby and blaming herself for lack of motherliness towards it. She thought that her husband would be better off if he left her. Her memory was quite good, and she was above average intelligence. She regarded her depression as a well earned punishment, could see no hope for the future and thought that even if the depression cleared up that there was only a useless personality beneath it.

Progress. Following admission she remained so depressed and self-depreciatory that no progress could be made with discussing her problems. She was therefore given a course of 7 E.C.T. and seemed completely well again. Following her first week-end at home she relapsed and during the subsequent month made no progress. She was therefore given another course of E.C.T. and once again has responded but at the time of writing has again relapsed, in spite of further attempts to discuss her difficulties.

Diagnosis. Depression following childbirth and closely related to the difficulties in her home circumstances.

Case 13. M.A. Aged 41. Multipara. Admitted 15. 8. 49. Home address - South East London.

Reason for Referral. Depression starting five months ago at the outset of her third pregnancy and persisting following termination and sterilisation one month ago.

Family History. The father was a cabinet maker and a rather quiet and reserved man. He and the mother got on quite well together but the mother, who was subject to depressions, had a depressive illness when she was 40 and was admitted to a mental hospital where she subsequently died of heart disease. The patient was more upset by her mother's death

than the other children as she was the eldest and ten years old when it happened. Before the mother's death the father was often out of work and at one time the family had to go on public assistance. Following the mother's death the patient and the other two children were put into the workhouse for a short time. The youngest sister (Case 5 W.S. in this series) was sent to the grandmother where she remained from the age of three until five. The father remarried two years later and the youngest sister (W.S) returned home and the patient (M.A.) was sent to the grandmother where she remained until she married. The stepmother and father quarrelled violently for the next five years and when the youngest sister (W.S) was ten, the father ordered the stepmother out of the house. During the years the stepmother was looking after them they were never properly cared for in that they had not enough to eat and were often ashamed of being sent to school dirty. There was no other mental illness in the family apart from the mother and each of the sisters recorded in this series as M.A. and W.S.

Personal History. There was no abnormality in the patient's early development except that she was a thin unhappy child. Her schooldays were uneventful, she was an average scholar, mixed with the other children and left in the top class when she was fourteen. After leaving she was sent out in domestic service where she remained until she was seventeen although she disliked the work and was poorly paid. She still lived with her grandmother throughout these years and when she was seventeen she got a job as a window dresser which had always been her ambition. She did well and stayed there nine years continuing to work even after she married. Her periods started when she was fourteen, their onset was not traumatic as she had had instruction from her grandmother, nor did she have any psychic changes subsequently in relation to menses. She had few boy-friends till she met her first husband when she was nineteen. He was three years older than herself, a regular soldier, and a jovial and sociable man. Their courtship lasted three years and they married in 1932. The marriage was a happy one, except that the patient was frigid. Their first child was born in 1935 after a normal delivery. Towards the end of the pregnancy she became mildly depressed and almost immediately after the child was born her depression became more marked. She returned to her own home for two weeks, then went back to her husband. He had no understanding of the fact that she was ill and thought that she was unhappy with him and wanted to leave him. He started to ill-treat her and she returned to her father but became so ill that she was admitted to hospital. She was given Cardiazol convulsion therapy and gradually recovered in six months. Her husband obtained a separation from her in 1936 and his parents kept the child. During the same year she had a further depressive illness, was in hospital for six months and recovered with shock treatment. She returned to her

old job and lived with her father. She seemed happy in her work but in 1938 she had a further depressive illness for which she was admitted to hospital. After six months during which time she had E.C.T. she recovered. In 1944 her husband gave her grounds for divorce. She met her second husband in 1947 when she was 39, and after a courtship of some months they were married in July 1947. He was an insurance clerk, seven years younger than the patient. Their marriage was happy except that she was still able to derive little satisfaction from intercourse. She wanted children and almost immediately became pregnant. At first she was well but from the third month of pregnancy gradually became depressed again and was referred to hospital when she was 6½ months pregnant. She was admitted almost immediately but disliked the hospital and discharged herself. She remained at home till her delivery in March 1948 and was in the maternity hospital for ten days. She was severely depressed on her return home and was admitted to a mental hospital, had shock therapy and was discharged completely recovered after two months.

Previous Personality. Normally a cheerful and energetic person who has been subject to mood swings since her first breakdown but not prior to that. She was always rather reserved and never had many friends, preferring more solitary pleasures. She was a capable housewife and if anything rather over-particular in her standards, and like her sister valued home life highly.

History of Present Illness. In February 1949 the patient became pregnant again and a month later the depression began to appear once more. In May 1949 she was referred to the hospital here from the ante-natal clinic in view of her previous history and the present recurrence of depression. Termination and sterilization was agreed to by the patient and her husband and was carried out in June 1949. In spite of this her depression persisted and she was admitted to hospital in August 1949.

State on Admission. Physically, there was no abnormality. Mentally, she was depressed, tearful, at times rather lethargic and at others mildly agitated. She was correctly orientated, but found it difficult to concentrate and had little interest in anything. She was of average intelligence.

Progress. She improved slightly after admission to hospital but gradually relapsed again. She was unwilling to have E.C.T. but finally consented and had three treatments. She improved rapidly but suddenly took her discharge from hospital on 15. 9. 49. She came up to the Follow-up Clinic a month later and appeared to have recovered completely.

Diagnosis. Depression occurring during a third pregnancy in a woman with four previous depressive illnesses and a strongly positive family history of mental disorder.

Case 14. M.B. Aged 39. Multipara. Admitted 29. 6. 49. Home address - North London.

Reason for Referral. Depression starting 6-7 months after the birth of a third child in May 1948.

Family History. The father was a French polisher who was inclined to drink heavily at times. The patient was his favourite child and she was very attached to him, more particularly as her mother died when she was only five, and shortly after this the patient was evacuated to the country, as the father served in the Army in the 1914-18 war. When she was ten she returned home, and lived again with her father, and when she was fourteen he remarried. The home subsequently became most unhappy as father and stepmother were always quarrelling. When she was sixteen the parents moved away leaving her in the care of a neighbour, but here too the atmosphere was unhappy as the neighbour and her husband fought constantly. The father died when the patient was twenty. She was the youngest of the three living siblings, a younger brother having died at the age of three. The stepmother had one child, a boy, who caused little rivalry in the family and ultimately died of T.B. The patient's only sister has subsequently been in mental hospitals several times, but no details of the type of illness are known. There was no other family history of mental illness.

Personal History. During childhood the patient had the one neurotic trait of sucking her fingers. She went to school first in London and subsequently in the country, during her evacuation. She was happy during the time there but learned little at the village school and on returning to London found she was backward compared to the others, and finally left when she was fourteen, two classes below the top. Her periods started when she was fifteen and she accepted them normally having been instructed by the neighbour who looked after her. There were no associated psychic changes but frequent headaches. When she first left school she stayed at home to look after her father but shortly after his remarriage she got a job. He was against this, laughed at her first small pay package, and finally insisted on her staying at home again as the stepmother wanted to go out to work. When the parents left her she took up laundry work and remained in that until after her marriage when she became pregnant with her first child.

She had two or three boy-friends from the age of sixteen onwards. She got along with boys all right but disliked it when they attempted to kiss her. There was no pre-marital intercourse and she never had any formal sex instruction. She met her husband when she was eighteen and became engaged to him when she was twenty-four. The husband was four years older than the patient, a stable personality, who worked first in the wine and spirit trade and subsequently as a furniture maker. Their courtship was a happy one but they did not marry till the patient was twenty-nine owing to lack of money. The marriage has been happy. The eldest girl, now aged nine, was planned but following her birth, the patient became depressed and easily tired, especially as the air-raids were bad at the time. She recovered six months later without having been hospitalised. This eldest child has been difficult to bring up, being over-excitabile and having frequent ear-ache. The last time this occurred was in November 1948 when the patient was already finding things pretty difficult in the home. The second child, now aged seven, was not planned, but the patient found it relatively easy to accept her as she was an easy baby and a quiet child. After the birth of the second child, the patient felt that she could not cope with any more children. At that time she began to get increasingly tense and anxious during sexual intercourse, frequently being left unsatisfied, because of the fear of further pregnancy. This tension was accentuated by the fact that coitus interruptus was practised, often not satisfactorily. Finally she became pregnant again and was extremely upset by this and worried constantly as to how she was to manage three children. During this time she often felt unduly tired and found housework more trying than usual. The child was born in May 1948 after a normal labour but was a breech delivery. The puerperium was uneventful except for two days of vomiting and diarrhoea and a slight rise in temperature which was attributed to food poisoning. On the tenth day she returned home, appeared anxious to resume her responsibilities, but seemed to have to push herself into it. She became easily tired and irritated with herself if she was too slow. The baby was irritable and cried a lot at night, especially after it started teething. She breast fed it for six months.

Previous Personality. She was always rather sensitive and self-conscious and tended to run herself down because of her poor educational level. She tended to think others were better dressed and cleverer than herself. She was sociable and active until the children came, but worried about them if she ever did go out, which was rarely. She worked obsessively

hard over her house and children, insisting on neatness and cleanliness, to an extreme degree, and nagging if things were not just so. Although predominantly cheerful she was prone to mood swings. In spite of her tendency to nag she was in many ways rather over-dependent on her husband.

History of Present Illness. In November 1948, about six months after childbirth, her slowness began to get more marked. She lost interest in everything and was unable to carry out her normal routine in the house. She had periods of depression which seemed worse in the mornings, and could not make up her mind about the simplest matters, such as meals. She would cry frequently for no apparent reason and became increasingly worried about not getting things done. At times she seemed tense and anxious, at other times she would sit about as if in a daze and keep repeating that the baby had put her routine out of order and that she ought never to have married or had children. She used to worry about going out alone and thought the neighbours would laugh at her and talk about her. She finally became quite unable to concentrate, would not eat, and slept badly, lying awake at night saying "Oh, God, help me to get well". "What am I going to do". She was afraid to be left alone and when her husband had to go to work would become irritable or tearful and threatened to commit suicide. Finally on 29. 6. 49 she was brought to the Out-patient Department and admitted immediately to hospital.

Condition on Admission. Physically, there was no abnormality, except that she was underweight. Mentally, she was tense, mildly agitated and wept when spoken to. She blamed herself for not being able to carry out her household duties, and felt the other patients might be laughing at her or talking about her. She was most self-effacing and tried hard to cover up the degree of her depression. She was correctly orientated and her memory was reasonably good. She was unable to concentrate and her intelligence and general information were slightly below average. She had fairly good insight into her condition.

Progress. She remained depressed, tearful, lacking in interest and concentration, feeling that she should never have married and had children, but missing her husband and children very much. She had a course of 6 E.C.T. to which she responded well. She had two or three successful week-ends at home, remaining well and able to cope with things. She was referred to a Birth Control Clinic following her discharge on 13. 8. 49. She has subsequently attended the Follow-up Clinic and seems to have made a satisfactory adjustment to her home.

Diagnosis. Depressive illness coming on gradually after the birth of an unwanted third child.

Case 15. E.D. Aged 35. Multipara. Admitted 14.7.49.
Home address - South East London.

Reason for Referral. Depression and inability to cope with household duties following the birth of a fourth child in March 1949.

Family History. The father was a retired gas-works employee, an Irishman, and a good father. The mother was a kind and hard-working woman who struggled to give her children the best, and to whom the patient was very devoted. There was one sister, a year older than the patient, with whom she got on well. The home life was always a happy one, the family were R.Cs but not particularly devout. There was no family history of mental illness.

Personal History. The patient's childhood was a normal one. She attended a Catholic co-educational school, but was never a very good scholar, and left when she was fourteen. She worked in two laundries after leaving school and stayed six years in her second job. Her periods started when she was fourteen and she was rather frightened as her mother had not told her, and regarded any matters pertaining to sex as not suitable for discussion. She had no psychic changes associated with her periods. She had two or three boy-friends before marriage but usually went out in a foursome until she met her husband when she was seventeen. They went out together for about four years before they started to have intercourse. This began one night when the patient had had too much to drink, and continued regularly until they finally became engaged when the patient was twenty-two. Coitus interruptus was used as the only means of contraception and the patient was fully satisfied by intercourse. When she was twenty-four she became pregnant. She was terribly upset by this and afraid to tell her mother. After a family row the mother accepted it, however, and they were married, although her family felt that he was of much lower social status than they were and did not like him. The husband was a year older than the patient, a wood-machinist and what now appears to be a psychopathic personality with a violent temper. To begin with the marriage was reasonably happy and intercourse satisfactory to the patient. She bore three children in 1938, 1942 and 1946 respectively, and had no trouble in their births, nor subsequently. As the children increased it was less and less possible for the patient to go out with her husband to the pub as was his wont and gradually he began to drink more and more and give her less money as a result. She in any case preferred to stay at home

but he would not do so. The marriage became steadily more unhappy. There was inadequate space where they lived in a top floor flat, no proper sanitary arrangements, nor a bath, and with the growing size of the family things became more difficult. With not enough money and not enough room and her husband coming in drunk night after night, the marriage went completely to pieces. She began to refuse to have intercourse with him. He accused her of having other men and finally said that none of the children, except the eldest, was his. He constantly nagged at her because he said she brought the children up too strictly and at times tried to set them against her. He went to the Probation Officer to complain that she would not have intercourse with him, but soon relented when the Probation Officer saw what the situation really was. About that time the patient became pregnant again and once more he accused her of infidelity and said the child was not his. Feeling that she could not face bringing up further children alone and under these circumstances she procured a miscarriage on herself in December 1947 when she was 3½ months pregnant. She had a severe haemorrhage and was taken into hospital for a D & C. After she came out she worried a lot about what she had done and became very depressed. In March 1948 she developed pleurisy and was again in hospital for a fortnight. When she returned home she was still rather depressed, although able to do her housework, but in July 1948 she became anxious as she had had no further period since the D. & C. She went to the doctor who told her she was again pregnant.

Previous Personality. She was always a good mixer and got on well with her neighbours. She normally was a cheerful person and sang about her work and never had any mood swings. She had always been a good housewife and worried excessively if things were not just so and could not bear things out of place or dirty. She was thrifty with money and saved up for things she wanted out of the small amount of money her husband gave her. She had always been sensitive and tended to worry over trifles.

History of Present Illness. When she knew she was pregnant again, she did not want the child, and although she was not grossly depressed she found it increasingly difficult to get her housework done. She had the baby in March 1949 after a normal labour and delivery. On her return home she became increasingly depressed and quite unable to cope in the house. She could not sleep and her appetite was poor. She sat around crying, lost all interest in everything and did not know what to do first. The children got on her nerves and she was only able to breast feed the baby for a month. She became terrified of the idea of intercourse and preoccupied

with fears of becoming pregnant again. In May 1949 she was brought up to the Out-patient Department by the husband who demanded that she be sterilised. Arrangements were made for admission next day. That night she became acutely agitated and had to be admitted to an observation ward. From there she was sent to a mental hospital where she had 4 E.C.T. and was discharged as recovered, but on the day of her discharge the baby became ill with gastro-enteritis. She relapsed again, could not do the work and was afraid of being alone. Her mother had to come in and do everything for her. Finally on 14. 7. 49 she was admitted to hospital here.

Condition on Admission. Physically, she had bilateral septic tonsils which soon cleared up with treatment. Mentally, she appeared depressed, retarded, and apathetic. She hardly spoke and when she did so it was only to blame herself for being unable to continue with her household duties. She had the feeling that people were watching her. She was correctly orientated and her memory and concentration were poor. She was of low intelligence.

Progress. After admission she made little progress but was constantly anxious to go home to try and look after her children. She was given a course of 6 E.C.T. and improved considerably. She was referred to a Birth Control Clinic as she preferred this to sterilisation. She went home for her first week-end and started to relapse again. The husband was seen and promised to co-operate. However he then wrote her a threatening letter and told her unless she came home and stopped enjoying herself in hospital he would have her certified. She wanted to try further week-ends at home, but things got steadily worse, he would give her no money, saying she could earn it on the streets. He told the children, in front of her, not to heed her as their mother was insane, and repeatedly told her the children were not his. She became more and more depressed and bewildered, wondering at times if what he accused her of was actually true. He was advised not to visit her in hospital and she has improved, and decided to try and get a separation from him and started a job while still living in hospital. She remains still mildly depressed and tense at the time of writing, as the arrangements for her separation have not yet been completed and she is very anxious about the children.

Diagnosis. Depression following childbirth and directly linked to the difficult marital situation.

Case 16. E.L. Aged 27. Multipara. Admitted 14.9.49.
Home address - South East London.

Reason for Referral. Depression and anxiety about homicidal thoughts towards the baby, starting 2 days after childbirth.

Family History. The father, a worker with Callender's Cable Co., was a quiet, retiring sort of man completely dominated by his wife. The patient always got on well with him although her ties of affection were more to her mother, but she resented the domination of her mother at the same time. In spite of the mother's attitude to the father, the parental marriage cannot really be said to be grossly maladjusted. The mother herself was a highly-strung, domineering, rather neurotic woman who became easily over-emotional. She had one illegitimate child which was born shortly after her marriage to the father and subsequently accepted as one of the family. By the parents' marriage there were three siblings of whom the patient was the second youngest. The other two, the boys of the family, were quite stable. The home life was quite a happy one apart from mild parental bickering but the financial position was pinched. They were all Roman Catholics, with the exception of father, the maternal grandmother who lived with them being particularly staunch and often telling the patient that if she ever lost her faith she would come back and haunt her. The grandmother died shortly before the patient's marriage, and this was a great shock to the patient who had been brought up by her more than by the mother.

Personal History. The patient's mother had a lot of vomiting in pregnancy when she was carrying the patient and the patient was the only one of her children not breast fed. As a baby she was always crying and used to be very jealous of her elder sister, who had a weak heart and was much fussed over. The patient was subject to nightmares and used to have one about a chocolate man or chocolate flowing everywhere. When she was $3\frac{1}{2}$ she developed what was considered to be a V.D. vaginal discharge and which she was said to have contracted from her mother. She was away from home in hospital for fourteen months; the mother hardly ever saw her but the grandmother visited frequently. She was educated at a Catholic School, was not a good scholar and did not take kindly to the excessive religious teaching. She left at fourteen in the top class. Her periods started when she was thirteen, and she was subject to depression during the menses, which have always been irregular. At this time the mother told

her a lot about sexual matters, including her own illegitimate pregnancy and advised the patient against men on these grounds. The patient was much upset to learn about her mother and blamed her for what she had done. After leaving school she had various clerical and factory jobs, often leaving for inadequate reasons and continued to work until the time of her second pregnancy, preferring to do so even though the money was not desperately needed. She had two or three boy-friends before marriage but took none of them seriously and had made up her mind never to marry because she considered "men were such devils". By this she meant they always wanted intercourse, never gave their wives enough money or else ill-treated them, an attitude which she seems to have derived from her mother. In 1942 she met her husband and in 1943 they became engaged and in June 1944, three months after the grandmother's death, they married in the Protestant Church, as the husband would not adopt the R.C. faith and his father refused to attend an R.C. wedding. The husband was two years older than the patient, an engineer, and very much attached to his relations, particularly his mother with whom they subsequently lived. The patient resented having to live with them and also the constant and overt demonstration of affection which went on between mother and son. The marriage was not satisfactory sexually, the patient rarely reached orgasm and intercourse often culminated in masturbation with guilt. The first child was born in May 1945. The patient had a normal pregnancy except for vomiting, which continued throughout. Ten weeks after delivery the baby got gastro-enteritis and died. There was a great deal of friction between both sets of parents, each blaming the other. The patient became depressed and had constant indigestion after the death and went to live with her own mother. She then developed a T.B. pleural effusion and was hospitalised until November 1945. In January 1946 her husband was called up and was away until December 1947. He was in this country throughout so that the patient was able to see him from time to time. After the death of her first child she never felt completely well, always rather depressed and with chronic indigestion. After her husband's return it was decided that she might feel better if she had another child, as her chest was by then clear, and she again became pregnant.

Previous Personality. She was normally a cheerful but rather over-anxious person, who worried over trifles. She was sensitive and took things to heart easily. She worried about her health and if anyone mentioned a complaint she thought she had it. She tended to be rather superstitious and had a great belief in many "old wives" tales. She was extremely houseproud and fussy about neatness both in her home and personal appearance. She had strict moral standards but since marriage had given up attending Church.

History of Present Illness. Throughout her pregnancy the patient again had excessive vomiting, and in addition was rather depressed and had various gastric symptoms. The baby boy was born on 16. 5. 49. after a normal labour and delivery. Two days after birth the patient became mildly depressed as the baby was not feeding properly, had frequent vomiting and had to be "fed with tubes". He apparently was treated successfully with Eumydrin and the vomiting stopped. On her return home the father-in-law was dying of a cerebral tumour. He behaved oddly and tried to strangle his wife at times and the patient began to fear he might strangle the baby. The mother-in-law interfered with the baby's feeding and would lick its dummy "to prevent germs" which worried the patient, who had more hygienic ideas. She gradually became more depressed and returned to her own mother. She developed thoughts about hurting or killing the baby, for instance, if she sewed she felt she was sticking the needle in the child and at times imagined her cigarette was burning his eyes out. The word 'unfanticide' kept coming into her mind. She was unable to sleep or eat and blamed herself for her ambivalent feelings towards the child. Finally she lost all interest in the baby and could concentrate on nothing. She developed a further T.B. pleural effusion after the birth and was greatly worried by that too. She finally became so ill that she was admitted to hospital on 14. 9. 49.

Condition on Admission. Physically, she was still slightly lactating in spite of having given up breast feeding some time before. There was a small right sided pleural effusion. Mentally, she was tense, anxious, considerably depressed, and talked of her conflicts over her religious beliefs and those of her husband, thinking that in the eyes of God she had never been married. She spoke of her ambivalence towards the child and her wickedness for having such thoughts about harming it. She had feelings of things crawling under her skin and had to wash repeatedly to try and rid herself of the irritation.

She was correctly orientated; was unable to concentrate. Her intelligence was average.

Progress. About six weeks after admission she was no better and it was decided, at her own request, that she should be married in the R.C. Church and the baby baptised into it. Following that she did not improve. Her religious and sexual difficulties were discussed with her, but her ideas of harming the baby got worse and she began to have unpleasant dreams about her grandmother and think that the V.D. she had had as a child had killed the first baby and might harm the second. She had one course of E.C.T. and, if anything, was rather worse. She was menstruating at this time. Further discussion of her problems still brought little improvement; she complained of having no normal affection for her husband and child, and six weeks after the discontinuation of treatment she was started on another course of E.C.T. and this time began to show improvement. At the time of writing, however, she has started to relapse again.

Diagnosis. Depressive illness starting after the birth of the first child, never completely clearing up and re-ignited by further childbirth.

Case 17. R.E.W. Aged 25. Multipara. Admitted 22.6.49.
Home address - South East London.

Reason for Referral. Depression starting after birth of a first child on 21. 11. 48 and becoming worse during a subsequent pregnancy.

Family History. The father was a motor mechanic, not a very intelligent man, Victorian in his outlook and little interested in his wife and children. The patient never got on very well with him as he had hoped she would be a boy and in his disappointment tended to favour the other sisters. She always considered both her parents rather unsympathetic. The mother never had much understanding of the patient's troubles and was an anxious, worrying personality, constantly seeking reassurance. She had a short depressive illness the year before the patient's admission. The patient was the youngest of the three sisters with whom she got on quite well. On the whole the home life was a reasonably happy one although frequently on the borderline of poverty.

Personal History. The only abnormality noted in childhood was sleep walking. She did reasonably well at school and left when she was fourteen to take up shorthand and typing. Her periods started when she was fourteen, the onset being very traumatic as she had had no instruction. Frequently during periods she would tend to become depressed. She had several boy-friends before she met her husband, and married

in June 1946. The husband was the same age as the patient, a telephone engineer and a stable personality. The marriage was a happy one, and sexually they were fairly well adjusted. Following their marriage they had to live with the patient's parents and although there was no gross disharmony things were at times difficult, particularly as the home was overcrowded. The patient was anxious to have children and wanted a home of her own. She first conceived during her honeymoon, but shortly afterwards had a spontaneous miscarriage. Subsequently they planned to have another child and it was a great shock to both of them when the patient again had a miscarriage. Her unhappiness was much increased by her mother's inability to understand and her persistence in comparing the patient's miscarriages with her own quite straightforward deliveries. In February 1948 the patient again conceived and looked forward very much to having her child. She was quite well during pregnancy.

Previous Personality. She was rather a quiet and reserved person and was always inclined to worry excessively about hurting other people's feelings. She was very religious, and had strict standards in that as well as in other matters. She was very energetic and normally cheerful. Her interests were mainly reading, painting in water colours and dancing.

History of Present Illness. She remained quite well until she went into labour, when she was rather upset by several events. She was placed in a bed near a dripping tap and when she requested that it be turned off this was refused. Later on the anaesthetic machine broke down. Her labour lasted twenty-seven hours, and a baby girl was born on 21. 11. 48. The patient had a severe tear requiring stitches. During the next ten days she remained in hospital, feeling weak and frightened, and very much upset by the rather callous handling of the nurses. On one occasion, having been given Castor Oil, she was left to wait an hour for a bedpan. When she returned home she found looking after the baby very difficult, was considerably depressed and unable to sleep. She felt she could not talk to her mother or ask for help because her attitude was so unsympathetic. She became more and more frightened and depressed and gradually began to hate her parents, her husband and her sister, who also lived at home. She was most severely depressed in the mornings and evenings, blamed herself for not being able to help in the house and because, at times, she felt rather muddled, she feared she was telling people lies. She contemplated suicide and finally broke down at the post-natal clinic. She was referred to the Out-patient Department of this hospital. She was advised to come in, but refused this and continued to

attend as an Out-patient. She began to improve gradually until, in May 1949, she missed a period and became very upset and depressed. Tests showed that she was again pregnant and on 22. 6. 49 she was admitted here for termination and treatment.

Condition on Admission. Physically, there was no abnormality. Mentally, she appeared tense, agitated and depressed, blaming herself for not doing her work at home and seeming very afraid of a further labour such as her last one had been. She was correctly orientated, her memory was good but she was unable to concentrate. She was above average intelligence.

Progress. The day following admission the pregnancy was terminated and thereafter her mental condition improved steadily although at times she was still agitated and a little depressed. She was discharged a week later. She was subsequently followed up as an Out-patient but remained mildly depressed and not very happy at home, especially in relation to her parents.

Diagnosis. Depressive illness occurring almost immediately after childbirth and related to inconsiderate nursing and difficult home circumstances.

Case 18. R.H. Aged 39. Multipara. Admitted 13.10. 49.
Home address - Kent.

Reason for Referral. Depression and inability to cope with household affairs starting one month after the birth of a third child in August 1949.

Family History. The father was a retired electrical research engineer of Quaker extraction. The patient was his favourite child and she was equally devoted to him in her childhood days, when she tried to emulate him in every way and take part in his activities, although he would often laugh at her. Later during adolescence she grew rather to despise him and disliked it when he made a fuss of her, feeling it as a deliberate insult to her mother with whom he did not get on. The mother was also a Quaker, and the patient was never able to get on with her. She was an over-anxious, obsessional personality, but nevertheless was always in a muddle as each individual thing had to be done too thoroughly. The patient's sister was equally thorough and this won the mother's favour, which made the patient resist learning any feminine accomplishments even more strongly. The mother often told the patient that she had wanted a boy, but in spite of the patient's tom-boyishness she was always displeased with her. The

patient was the youngest of the three children and although jealous of her sister, was extremely attached to her brother and enjoyed his games far more than playing with dolls. He always seemed to "get away with things" and the patient felt it was very unfair as she was always more ingenuous and always got caught. The home was never a happy one, with constant and violent battles between the parents culminating in their divorce when the patient was fifteen. The father remarried not long afterwards and on the occasions when the patient saw him subsequently there was a great deal of jealousy on her part towards the wife and second family. There was no family history of mental illness.

Personal History. When the patient was $3\frac{1}{2}$ the family moved to London and during her younger days she would play most boys' games with her brother and the boy who lived opposite who was ultimately to be her husband. In spite of her tom-boyishness she was a shy and sensitive child and afraid of the dark, and of enclosed spaces. She was sent to a Quaker boarding school when she was ten and told by her mother she was being sent because she was naughty. She was much bullied and was no happier there than she had been at home. Her periods started when she was at school but she had previously been instructed on this and all sexual matters by her mother, usually getting more information than she asked for at any one time and being therefore rather shocked and embarrassed by it. The school was co-educational and the patient had several "crushes" on other boys and masters. She was never bright at school, failed her matriculation and left when she was seventeen. She had a job as a Librarian for six months after leaving school but felt very lonely and returned home to the mother who suggested a training in an Art School, considering it rather Bohemian and romantic. The idea was opposed by the father but the patient started her training, living meantime in a mixed hostel. She fell in love with a young man there who wanted to live with her, but her mother and brother intervened and she took a flat with a girl friend. She stayed three years at the Art School and got her Diploma. When she wanted to go to America to study commercial art her father refused to pay for it and he and his second wife persuaded her to take a Nursery School training. As she had to be trained free of cost she had to work extremely hard and the training was not good. At that time she became engaged to a pleasant but ordinary man. Towards the end of her year of training she developed scarlet fever and was extremely ill. Subsequently she took a job as a nursery maid in a vicarage. The work was too hard, she was lonely and rather treated as if she were a domestic servant, so she left there and went to look after her father's young family. She was not happy there either as

her stepmother flirted with her fiance in order to show her that he was shallow, and ended up by persuading her to break off her engagement. Again she returned to her mother who suggested that she return to the Art School. She worked hard on the Commercial Art Course and during that time met her husband again. He was a year younger than herself, also a commercial artist, and as insecure as the patient herself. When she was twenty-six they started living together and continued to do so for the next two years. With his encouragement she got a good job in which she stayed for the next five years. During the time they were living together the question of marriage was debated, she wanting it, and he not, considering the financial strain of children would be too much. Finally she persuaded him to agree and they were married. After they were married the patient kept her husband for a year while he went into industrial art, and gradually she seemed unable to derive confidence from him any more. She thought if she had a baby it might help, and saved up to £100 so that she would not have to be dependent on her husband when the baby came. She had the baby, a girl, in 1941, after a difficult forceps delivery. The child was jaundiced and they would not let her see it for 24 hours and she was convinced it was dead or deformed. A week later her husband was called up. The patient gradually became more and more impressed with suicidal ideas and was treated by a psychiatrist for four months, when she returned home she found it very difficult to cope with learning to do domestic chores and look after the baby. She was seeing her husband frequently and was still determined to have a son. After a great deal of argument she again persuaded her husband to let her become pregnant. Her husband had been withdrawn from the Army by the Ministry of Supply in which he had been prior to call-up and was living at home. When she had the second baby she practised Dick Read's relaxation exercises before the birth and the delivery was very smooth and gave her a great deal of satisfaction. The child was born in 1943 and was another girl. She was greatly disappointed by this and found breast feeding a great strain. The child developed a type of steatorrhoea and was difficult to rear, the patient having many sleepless nights and becoming steadily more irritable. There were constant rows between herself and her husband who refused to give her any help, not having wanted the child himself and feeling that his work was more important. During the years which followed the quarrels grew more frequent, the husband feeling that the marriage was hindering his work and the patient, who had many offers of jobs herself, always turning them down. On several occasions the husband threatened to leave her. In spite of all this she was still determined to have a son, and the friction between herself and her husband grew more intense as she tried to persuade him. He was against having further children and in any case preferred girls.

Previous Personality. Always a sociable person, she belonged to various camping and youth movements such as the Order of Woodcraft Chivalry and Kibbo-Kift. Before her marriage she was a cheerful person but during the years became more prone to get depressed over trivialities. She was always a worrying, anxious, insecure personality, hypersensitive to adverse criticism, self-conscious, and unable to get enough praise. She always had high ideals about neatness and tidiness but got so slow in trying to achieve these that chaos usually resulted whereupon she became anxious and guilty about it. She saw both sides of every question to such a degree that action was delayed or prevented altogether, resulting in endless intellectual arguments. She always hoarded things and was never able to throw anything away. Her religious standards were very high and being a Quaker she believed in non-violence. Her standards in work were likewise high and she constantly felt a failure because of her inability to achieve these standards. She was always mildly hypochondriacal. She was resentful of authority but became anxious when she destroyed it. She was able to give excellent advice to others, helped her boy-friends to become emancipated, by destruction of their parental ties, but had no constructive drives.

History of Present Illness. Against the wishes of her husband she finally became pregnant again, had an excessive amount of vomiting throughout the pregnancy, and grew even more insecure than before. After the fifth month of pregnancy she began to worry increasingly over trivial matters, particularly about money. The degree of pessimism which had been getting more pronounced for the last two years became even more marked and she became excessively concerned about the other children. The baby was born in August 1949 and was another girl. She was given an anaesthetic during the labour and looked upon this too with a sense of failure. Almost immediately afterwards she began to worry about her mother who was never efficient and was having to do everything at home. She gradually developed more and more fears for the future and after she had been home a month found it increasingly difficult to get things done, found disadvantages in every proposal made and finally became completely indecisive. She became excessively sensitive to noise and was unable to sleep, felt completely useless and said that there was nothing left to live for. She was in a constant state of anxiety for fear she would

lose her milk and felt it her duty to continue breast feeding. Her appetite was, if anything, excessive. She felt guilty about being unable to cope with things and for losing her temper with the other children, and overburdening her mother. She was seen at a post-natal clinic and because of her depressed and anxious state was referred to the Out-patient Department and admitted to hospital the following day.

State on Admission. Physically, there was no abnormality. Mentally, she appeared extremely tense and anxious and moderately depressed. She was mildly aggressive in manner and hypercritical of ward arrangements for the baby who was admitted with her as she insisted upon continuing with breast feeding. She was correctly orientated; her memory was good, but she was unable to concentrate. She was above average intelligence and had fairly good insight, but could see no hope for the future.

Progress. Following admission she took a long time to settle down, remained critical, mildly aggressive, and at times very depressed and anxious. She became gradually very dependent on the ward sister and her doctor and her anxiety and depression began to abate, although her indecisiveness was still very apparent and she could not see how she was going to cope. Discussion of her problems produced further improvement but she still remained over-anxious about the baby. She constantly rejected it in minor ways and spoke about having it adopted. When, however, it failed to gain weight or made only small gains, her anxiety and depression returned in full force at which times she would constantly demand reassurance and although able in some degree to accept it, she would question and mistrust the advice given, and those who gave it. Her husband was also seen frequently and arrangements were made for him to have psychotherapy as an out-patient, in order to try and get him to accept more responsibility in the domestic situation. She eventually had several successful week-ends at home in which she coped quite adequately and responded well to her husband's adoption of a more authoritarian role. She was eventually discharged after three months in hospital, by which time she was anxious to start coping with her home and children again. A full-time Home-Help was arranged for her and she was referred to another Hospital's Out-patient Department nearer her home in order to fit in with breast feeding times, and at the time of writing seems to have settled down.

Diagnosis. Depression with associated anxiety features occurring after the birth of a third unwanted female child, in an insecure woman with marked personality difficulties.

Case 19. V.P. Aged 29. Multipara. Admitted 22.11. 49.
Home address - South East London.

Reason for Referral. Depression, agitation and inability to cope with household duties, starting three days after the birth of her second child.

Family History. The father was a retired stoker, a quiet man with whom the patient always got on well apart from one episode in her life. The mother died of T.B. when the patient was seven and she could not remember much about her. After the mother's death the patient was looked after by various relatives until the father remarried again, two years later. The patient and her stepmother never got on well together and the former never felt she replaced her own mother. The patient was the third youngest of seven siblings, all of whom have died of T.B. with the exception of one sister. This sister lost her first child, at the age of ten months, and has recently been very "nervous" following the birth of her second child. There was no family history of mental disorder.

Personal History. During childhood the patient walked in her sleep. She attended an open-air school because of the family history of T.B., although she herself never had it. She was not an outstanding scholar. Her periods started at fourteen and were subsequently very irregular but there were no psychic changes and she accepted them normally. After leaving school she was put into domestic service by her stepmother against her own wishes and had several changes of jobs, never really settling to any of them, as she did not consider herself suitable to domestic work. In 1941 she joined the A.T.S. and gradually worked her way up to the rank of Sergeant and enjoyed the life. In 1943 she met a married man, five years older than herself and was flattered by his attentions as she was rather plain, and he very attractive. He danced with her several times at parties and on one occasion after they had had a good deal of drink, there was an isolated episode of intercourse. He was posted shortly afterwards and the patient then found she was pregnant. She was terribly ashamed, particularly as she herself was responsible for seeing that the Other Ranks did not get into similar difficulties, also because she had always been rather prudish in sexual matters and had had no previous sexual experience. She did not really realise she was pregnant till she reached the third month as she had had no adequate sexual instruction. She was

discharged from the Services at 3½ months pregnant and one of the Officers found her a job. Her own parents disowned her. Her pregnancy was normal except for a rather high blood pressure. She was taken into hospital when already in labour and was extremely afraid as the child was almost delivered in the ambulance. Her puerperium was uneventful and she returned with the baby to her previous post and left there when the baby was five months old. She had a series of domestic jobs following that but found difficulty in getting posts because of the baby. The idea of having it adopted did at times cross her mind, but she felt unable to part with it. Finally, when the baby was ten months old, she was particularly unhappy in a job and decided to gas herself and the baby. The baby woke up in the middle of it and the patient abandoned her attempt. After that she spent a year with her aunt but the aunt became too possessive with the baby and there were several disagreements during which the aunt finally told her to go. She had several jobs, lived in furnished rooms, and put the baby in a day nursery. When the nursery closed the patient went to a Welfare Association and they found a foster home. This was not satisfactory and in the end the child was moved to a children's home. In the meantime, in 1945, she met her husband, a man five years older than herself. He was an only child whose mother died when he was two and who had subsequently been brought up by an aunt to whom he was greatly attached. He had been married previously, while he was a hospital porter, to a nursing sister thirteen years his senior. This lasted about a year and they subsequently got a divorce. He had had many changes of jobs since, and had been turned down for the forces with chronic nephritis, and was a rather strange, affectless individual, rather detached, a strong congregationalist, his main interests being tapestry sewing and rather angular oil painting. They were not in love, but for the sake of security the patient married him in March 1948. She, in spite of not wanting a child so soon, and even then regarding it as payment for her security, became pregnant almost immediately. The landlady where they were living refused to keep them on and the patient's husband got a job as Church Caretaker with a flat attached to the job. This proved to be very unsatisfactory from the patient's point of view as she was expected to do a great deal of work, cleaning, making tea and washing up after meetings. In addition her husband was most unreliable in his part of the work, would forget to put water in the font for christenings, etc., unless the patient was constantly behind him. In addition to all

this her elder child came back to live with them when the patient was seven months pregnant, thus adding to her work. Her marriage was not happy because of these difficulties and sexually she was completely frigid and always prudish and embarrassed with her husband. The pay that they got for their work was poor and they required every penny of the extra money the patient earned by making tea, etc., to make ends meet.

Previous Personality. She was normally quite a cheerful person and found it easy to mix with people, but was usually rather pessimistic about things. She always had a tendency to mood swings, was sensitive, and rather self-conscious and reserved. She was over-fussy about her personal appearance and was houseproud to the point of discomfort. She considered if a job was worth doing then it was worth doing well; had high standards and became anxious if they were not fulfilled. She always wanted to get on socially. Although she had no particular religious standards of her own she adopted the congregationalist tendencies of her husband.

History of Present Illness. The patient had a lot of vomiting during the first six months of pregnancy and at three months she began to get rather depressed. At the seventh month of pregnancy they moved into their flat and the patient became much more depressed, wept frequently, and found her household and other jobs getting too much for her. She was afraid that she might have the baby while unattended and thought with misgivings of her first delivery. There were students present at the labour, also when she was being stitched for a tear, and she disliked this very much. On the third and fourth days of the puerperium she was depressed and had severe migraine. She returned home on the twelfth day and rapidly got more and more unable to cope with things. She breast fed the baby for $9\frac{1}{2}$ months and made rather a point of this. She got so that she was unable to concentrate, was very slow, which added to her sense of frustration, and on occasions she would smash things in her irritation. Her depression deepened, she let her household duties slide, thought of committing suicide and killing the baby and was constantly irritable and aggressive to the older child and her husband. She was over-anxious about trifles, lost her appetite and was finally seen at the Out-patient Department and admitted to hospital on 22. 11. 49.

State on Admission. Physically, there was no abnormality except that she was underweight. Mentally, she was tense and anxious, unable to concentrate and frequently wept. The slightest noise upset her and she would become extremely agitated. She had no feeling for her husband and elder child and was over-anxious about the baby. She tended to interpret minor events as being directed against herself; blamed herself for being ill and for taking everything from her husband and giving nothing in return. She was correctly orientated and her memory was quite good. She was of low average intelligence.

Progress. Since admission she has remained in much the same state until recently, when she has begun to respond to discussion of her problems; is less depressed and her anxiety is abating. She refuses to return to her present flat and still has a great deal of guilt about husband and children. At the time of writing, however, she is making steady progress and beginning to try and cope with her problems.

Diagnosis. Depression and anxiety following child-birth and largely attributable to social factors and maladjustments in the marriage.

Case 20. M.L. Aged 59. Multipara. Admitted 18.11.49.
Home address - South East London, recently moved from Manchester where she was born and bred.

Reason for Referral. Agitation and depression in an elderly woman who had had a mental illness following the birth of her first child.

Family History. Owing to the age of the patient and the absence of reliable informants the family history is lacking in detail. It appears, however, that the patient's father died many years ago. He was a labourer and quiet and steady. The mother, whom she cannot remember, died when she was seven and she was looked after by a housekeeper until the father remarried. The second marriage was not a success and eventually the stepmother took to drink and the home was broken up. The patient disliked the stepmother who treated her unkindly and took any small sums of money away from the patient and her two siblings. When she was twelve she was sent to her great-aunt and got on reasonably well with her. The patient's sister was highly excitable, and she and the patient never got on and the brother was a heavy drinker.

Personal History. Nothing is known of the early development but the patient bit her nails until well into adult life. She did well at school, reached the

top class and was advised to try for a scholarship. The stepmother, however, forbade this as she wanted the patient to go out and earn and she was therefore removed from school at twelve and put into domestic service. She remained in this type of work until after her marriage. The exact age of her menarche is not known but at any rate her periods remained very irregular until she was seventeen. Although there were no associated psychic changes she hated having periods and would have much preferred to be a man. She had one or two boy-friends before marriage, but on the whole, although she preferred men's company to women's, she got very tired of the boy-friends as they never seemed to be serious, Whenever they attempted to make any sexual advances to her she refused to go out with them again. She finally met her husband in 1910. He was four years older than herself, a printer by trade and a quieter type than the other men she had known. They had a happy courtship and married in May 1912. Intercourse was infrequent and unsatisfactory to the patient who actively disliked it. She did not want a child for some time after marriage as her husband's financial position was insecure, but she soon became pregnant. She remained well during the pregnancy but was terrified at the prospect of childbirth and was regaled by neighbours with many frightening tales. She had little notion of the actual process of birth and they did not see fit to enlighten her on this more important point. She was determined to have only male children and after a somewhat difficult delivery in which instruments were used, a son was born in May 1915. During the next few months the baby was cross and difficult with feeding, and the patient worried about her husband's financial state. She gradually became irritable and more and more unable to cope with her household tasks until finally she was admitted to a mental hospital eleven months after the birth with a depressive illness which lasted nine months. It was nine years before she attempted to have another child but she herself says that being older and knowing what to expect she faced the second birth with no misgivings, had another son and no associated breakdown. She remained always over-possessive with her sons, but got on badly with both, especially the elder one. During the war they served overseas which caused her much worry, which was accentuated by the sudden death of her husband in 1942. The sons returned in 1945 and in 1947 the younger married; the patient disapproved of the girl and refused to attend the wedding. She again disapproved when they had a child a year later, as she thought it too soon. She quarrelled with her eldest son who left home and finally in August 1949 she sold her house and came to

live in London with her younger son preparatory to finding a place of her own.

Previous Personality. In spite of preferring men's company to women's she was a militant feminist and a strong believer in the equality of the sexes. She was always excessively prudish about sexual matters. She was a thorough worker and full of energy, obsessional and too methodical about the tidiness and cleanliness of her house and her personal appearance. When she was ill after the birth of her child she could not get things done in her usual way and would stay up half the night working. Her obstinacy and independence were striking features of her personality and she always was a leader and organiser and determined to have her own way.

History of Present Illness. This will be recorded very briefly as it does not pertain to childbirth, but it seems that after coming to London in August 1949 she was unable to get on with her daughter-in-law whose housekeeping did not come up to her own meticulous Lancashire standards. There were numerous rows culminating in a more violent one at the beginning of November. Following it the patient became agitated, depressed and unable to sleep. Finally she made a somewhat dramatic suicidal attempt with some phenobarbitone tablets, as a result of which she was admitted to an observation ward on 8. 11. 49. and subsequently transferred to this hospital.

State on Admission. Physically, there was no abnormality other than a mild bronchitis. Mentally, she was tense and over-anxious to please, emotional in discussing her difficulties and at times mildly aggressive. She tended to blame herself for being against her son's marriage and for ever going to live there. At times she felt that everybody was against her. Twenty-four hours after admission she had a period of extreme agitation associated with weeping, but this passed off in a matter of hours. She was correctly orientated, her memory on formal testing was quite good although she was poor on dates in giving her history. She was unable to concentrate. Her intelligence and general information were average.

Progress. She settled down rapidly and soon became emotionally more stable. She was anxious to make plans for the future and with the help of the P.S.W. eventually found two rooms in which to live, and which suited her. Her relations with her son became satisfactory and she was discharged on 24. 1. 50.

She will be attending the Follow-up Clinic where the P.S.W. will be able to help her over any further domestic crises.

Diagnosis. An agitated depression precipitated by domestic difficulties, in an elderly woman who had had a previous mental illness related to childbirth.

Case 21. A.K. Aged 31. Multipara. Admitted 9.8. 49.
Home address - South East London.

Reason for Referral. Depression and hypochondriasis starting three months after the birth of a second child.

Family History. The father was an unstable man who drank heavily, had a violent temper and could never keep a job. His brother finally sent him to South America, but once there he again lost his job, and the patient's mother left him and returned home. Seven years later the father came back to fight in the first World War and he and the mother set up home together again. Shortly after this the patient was born, by which time the parental marriage had again become most unhappy with constant fighting. The father was particularly fond of the patient but she was more attached to her mother and it was a great shock to the patient, who was then fourteen, when her mother suddenly left the home, being unable to stand the constant rows any longer. Thereafter the patient and her father lived first with a great-aunt, and then with the patient's sister-in-law and finally with a brother, but they were turned out of each place owing to the father's violent temper. Finally the patient ran away and returned to her great-aunt. She lived there until she was nineteen and then both the aunt and her father died and the patient returned to her mother. The patient was the youngest of four siblings the eldest of whom was twelve years older than herself. The brother next to her was adopted at the age of three by the aunt, with whom the patient ultimately went to live, and this brother was electrocuted at work a year before the aunt's death which was a severe shock to the patient. There was no family history of mental disorder but the paternal grandfather drank heavily.

Personal History. The patient's early development was normal but she was fussy about food in childhood. Her periods started at eleven and she was usually depressed and irritable during her menses. She became rather nervous by the age of twelve, was afraid to go out in the dark and became terrified if a man looked at her in the street. She did well at school, winning a scholarship to Central School

and leaving in the top standard at fourteen. After leaving school she became apprenticed to a tailoring firm where she stayed for four years, but subsequently had a number of different jobs, often leaving for rather inadequate reasons. She had several boy-friends and finally met her husband when she was nineteen and first lived with her mother who was then staying with her step-sister. The patient's husband was her step-cousin three years younger than herself, a tram-conductor, and an easy going but rather weak and unimaginative character. They became engaged when the patient was twenty-one, and it was at this time she developed a mild depressive illness, refused to eat and became convinced that she had swallowed a tooth-brush bristle which might get stuck inside. This lasted one month but cleared up without hospitalisation. A year later they married. The marriage was happy and sexual intercourse satisfactory to both, coitus interruptus being practised. A year after marriage the husband was called up and ten months later, when the patient was four months pregnant with her first child, he was sent overseas. She was upset by this but not unduly so and went through a normal pregnancy and delivery apart from excessive vomiting. When the baby was three weeks old she had to take over full responsibility for it as her mother went into hospital. When the baby was eleven months old she got a job as bus conductress and her mother looked after the baby. She began to find her stomach "played her up" and she had frequent attacks of diarrhoea, so that she was forced to abandon the job, and the mother went out to work instead. In 1945 the husband returned home and they resumed their married life quite smoothly. The mother lived with them and acted as housekeeper. Their flat was, however, unsatisfactory, and overcrowded. In December 1946 she found out that her husband was in love with her best friend and there was considerable unhappiness at this time, particularly as in March 1947 the patient realised that she was pregnant. She was again going out to work to supplement her husband's poor pay and in May 1947 had a spontaneous miscarriage. This, she said, seemed to bring her husband to his senses and she had no doubts about his fidelity in the following year when she again became pregnant. She did not want the baby but superficially accepted it, although she had an excessive amount of vomiting during pregnancy. Her husband was worried about the pregnancy because of his poor pay. Labour was prolonged but otherwise normal and the child was born on 30. 1. 49. A fortnight afterwards she had 'flu', lost her appetite and seemed depressed, and her milk left her so that the baby had to be weaned. She appeared to recover in about three days.

Previous Personality. The patient was always rather over-dependent on her mother and this was more marked even since she was married and had children. She was normally an energetic person and was very fussy about her house, where everything had to be just so, and also about her personal appearance. She was meticulous in money matters. She tended to be "highly strung" and had a quick temper. She never mixed easily and was over-sensitive but normally not at all hypochondriacal.

History of Present Illness. Three months after the birth of the child she began to complain of pains in the head, as if a knife were being stuck into it, and started to lose her appetite. Gradually she became depressed and would sit for long periods staring into space and not speaking. She was sleeping badly, seemed disinterested in everything, and was very slow in her movements. In spite of being given Dexidrene by her doctor she did not improve and shortly before admission refused to go out alone because she feared she would not get back again. Her mother had to do everything for the baby, in whom she showed no interest. Finally she could not be persuaded to do anything, and sat about repeating over and over "what shall I do?" grasping hold of people seeking reassurance, or rubbing her hands together constantly. She said she felt panic stricken. She became extremely hypochondriacal thinking that minor things meant serious illness, and that even if her tongue were furred it meant she had thrush. She was finally persuaded to attend the Out-patient Department and was admitted to Hospital.

Condition on Admission. Physically, there was no abnormality. Mentally, she appeared tense, anxious and mildly depressed. She complained of pains in the head, furring of the tongue and sore gums, and begged for reassurance that there was no physical disease. She tended to blame herself for trivial matters. There were no hallucinations and she was correctly orientated. Her memory was quite good, but she found it difficult to concentrate on anything but her physical state. Her intelligence and general information were average.

Progress. She improved during the first fortnight

in hospital but relapsed again at the onset of menstruation. Her depression became much more marked and she was constantly seeking reassurance about various minor physical complaints. She was quite unable to accept reassurance and a few minutes later would return with the same questions and ever growing agitation. Her appetite was poor and she slept badly. She was given a course of 6 E.C.T. during which time she was once more menstruating. She became worse during the E.C.T. until the last treatment when her depression seemed to lift a little. Two further E.C.T. were given and her depression showed marked improvement. She remained mildly agitated and hypochondriacal until October and then steadily improved. She had several week-ends at home during which she resumed her household duties satisfactorily and was discharged on 2. 11. 49. She attended the Follow-up Clinic after discharge and seemed to have made a satisfactory adjustment at home.

Diagnosis. An agitated depression with hypochondriasis occurring after childbirth in a woman with a disturbed early home life, a previous mild breakdown at the time of her engagement, and some recent marital difficulties herself.

Case 22. A.S. Aged 27. Multipara. Admitted 23. 5. 49.
Home address - South West London.

Reason for Referral. Depression with paranoid features following the birth of a third child.

Family History. The father who was a stevedore died in 1930 of tuberculosis. The whole family, including the mother and the patient, who was his favourite child, were afraid of him. He had a violent temper, drank heavily and wasted his money gambling. With what money he had left he bought the children's clothes, giving them no choice in the matter. He constantly nagged his wife so that she dreaded his homecoming. He had been married previously and had had two children, both of whom had died. The mother died in January 1946 of cancer of the liver. She had also been previously married and by that marriage had two children whom the patient's father ill-treated. The patient's mother was a kind, hard-working woman to whom the patient was devoted and sympathised with her in her difficulties with the father. The patient had five siblings, one of whom was mentally defective, and died at six months. The patient was particularly attached to her elder sister with whom she shared all her activities until the time of her marriage. The home was very poor because of the father's habits and the fact that he was frequently out of work because of his chest condition and the mother often had to go to the Relief Centre to get food.

Personal History. The patient was a nervous child, spoke with a lisp until she was ten, was afraid of her school teachers and of the dark, the latter having continued into adult life. She had chorea when she was seven, as did her youngest sister. She was keen on studying at school, but failed to get a scholarship and left in the top class when she was fourteen. After leaving school she had numerous office jobs and after her father's death helped to support her mother. Her periods started when she was thirteen, she was very shocked by it as she had had no instruction, nor did she have any sexual instruction and did not know where babies came from till after her first child was born. She met her husband in 1937 and had frequent pre-marital intercourse with him although she regarded intercourse as something shameful. No contraception was used and she was terrified in case she should become pregnant and disgrace her mother. She became pregnant in February 1940 and the mother-in-law to be created a scene, took her to a chemist and made her take some drugs to produce an abortion. This was unsuccessful and they were married in June 1940. The husband was three years older than the patient, a coach-builder who was invalided out of the Army in 1942 with a psychiatric disorder for which he was treated in a mental hospital with E.C.T. He was never able to provide a stable home for the patient owing to financial losses and unsuccessful business projects and she was always resentful about this. In November 1940 their first child was born with spina bifida and died a few hours later. During the pregnancy the patient had been quite well, but was considerably depressed and upset after the baby's death. Shortly after the death the patient's husband deserted from the Army and although they lived in different places she had to support him, and it was some time before she persuaded him to go back. He was discharged on the grounds of "nerves" shortly afterwards and returned home. In June 1945 her second child was born and in July 1946 they moved to the flat in which they now live. At first things were satisfactory but gradually as the baby started crawling the neighbours would bang on the ceiling at the slightest noise. In order to avoid this the patient would take her child out every afternoon whatever the weather and found difficulty in getting her housework done. All this was a constant source of worry to her and the

child began to show the mother's anxiety by becoming frightened, frequently crying, having nightmares and facial tics. Finally, in 1947, he had to be taken to a Child Guidance Clinic. In 1947 she became pregnant again, was depressed during pregnancy and in January 1948 the third child was born.

Previous Personality. The patient was not a good mixer and never had any friends or social contacts and depended entirely on her home for her satisfactions. She was always subject to mood swings although this has been more marked since having children. She was always over-sensitive and dreaded going out to restaurants for meals. She was always rather suspicious and quick tempered. She was socially ambitious for herself and her husband but felt ill at ease with people of better social class than herself, and resented her husband's inability to provide better things for her. She always had high standards of cleanliness and was very particular about her house, working from morning till night to keep things in order.

History of Present Illness. Gradually after the birth of the third child in January 1948 she became more and more depressed and worried about the children making a noise and disturbing the neighbours. She lost all interest in sexual intercourse which previously had been satisfactory to her and began to "feel like screaming if her husband touched her". She worried about becoming pregnant again in spite of the fact that contraception was used. She was unable to sleep properly and got up at night and wandered about the house. She got gradually more and more behind with the housework. After her child had thrown a brick at another one and because of the unpleasantness with the child's mother, the patient again felt compelled to take the children out every afternoon. The neighbours also made some accusations about the family having black market coal, which upset the patient further. Finally she became so ill that the hospital where she was taking her eldest child for guidance referred her to this hospital as an Out-patient. She was treated as an Out-patient for two months but her depression became even more marked; she threatened to commit suicide, developed paranoid ideas about the neighbours and was admitted to hospital on 23. 5. 49.

State on Admission. Physically, she showed tachycardia, tremulousness and sweating but there was no organic abnormality. Mentally, she appeared very tense, agitated and mildly depressed. She was convinced that the neighbours were annoying her deliberately to get her out of the neighbourhood because she was "not their kind". She interpreted the domestic difficulties and minor quarrels with the neighbours' children as part of a plot. She maintained that when she spoke to the neighbours about the prevailing atmosphere that they were nice to

her face about it but that the persecution continued just the same. She was not hallucinated and was correctly orientated. Her memory and concentration were fairly good and she was above average intelligence.

Progress. She improved gradually with psychotherapy during which she expressed a considerable amount of hostility towards her husband and his inability to provide a stable social background and also guilt in relation to the death and developmental abnormality of her first child. Finally she was discharged symptom free on 5. 9. 49 and the P.S.W. was asked to deal with the housing problem. Following her discharge the patient relapsed slightly and attended the Out-patient Department regularly. Finally she decided to put the children in a nursery by day and got a job herself. Since then she seems to have settled down satisfactorily.

Diagnosis. Depressive illness with paranoid features developing gradually after the birth of a third child and related to difficult social circumstances.

Case 23. W.S. Aged 33. Multipara. Admitted 27.8.49.
Home address-South East London.

Reason for Referral. Depression starting two months after the birth of a second child in November 1947.

Family History. See M.A. Case 13.

Personal History. The patient's early development was normal except for bed-wetting which persisted until she was ten years old. At school she was an average scholar, but during those days was constantly worried about the troubles at home and ashamed of the dirty state in which they were sent to school. Her periods started when she was eleven and were always irregular, and associated with increased irritability. After leaving school she had three different jobs, in the last of which she remained for seven years and it was here she met her husband. He was two years older than herself, a bakelite moulder, and an energetic and organising man. They knew each other for three years before they finally married in 1936. In the early days of their marriage the patient was very happy, apart from their sexual life which was maladjusted, the patient rarely, if ever, reaching orgasm. She

She was anxious to have children and in August 1937 her first child was born. He was an easy child to manage but six to eight weeks later she developed a depressive illness and was admitted to hospital. She recovered six months later. At the beginning of the war the patient's husband was put on to Government work and in March 1942 was sent to Lancashire. The patient continued to live in London with her son, but in September 1942, she began to get depressed again. In October 1942 the child had mumps and the patient's depression became worse. She finally attempted suicide and was admitted to hospital in November 1942. She had a course of E.C.T. and three and a half months later had recovered. Soon after this her husband returned to London, but the marriage became increasingly unhappy. In spite of this the patient remained well apart from frequent severe attacks of migraine. There were numerous arguments because her husband joined a men's club and enjoyed organising things there, frequently leaving the patient alone at home. She had always wanted a home life after her own disturbed early home background and was unable to make him see the importance of this from her point of view. She was anxious to have a baby girl and thought that this might compensate for her husband's frequent absences from the home. She became pregnant again and remained well during pregnancy, apart from increasingly frequent attacks of migraine.

Previous Personality. She was usually a cheerful person but had a tendency to short periods of depression and irritability. She enjoyed home life, and was an efficient housekeeper with high standards in her home. She was inclined to worry excessively over trifles and was self-conscious in company.

History of Present Illness. A baby girl was born on 6. 11. 47 after a normal labour and delivery. Immediately after the birth the patient felt "strung up" and "wanted to scream" but apparently settled down before she returned home. About two months after delivery she began to get depressed and lost interest in the housework and the baby, which started to lose weight and had to have supplementary feeding. She remained in this state for three weeks and at the same time she had more severe attacks of migraine. Her depression then changed into mild hypomania which lasted one month and then again relapsed into depression. She gradually became very retarded and unable to sleep. She finally collapsed during an attack of migraine, was admitted to an observation ward on 19.8.48 and from there was transferred to hospital.

State on Admission. Physically, there was no abnormality. Mentally, she showed retardation and depression of moderate degree. She was unable to concentrate and did not want to mix with other people. Her orientation was correct and her memory reasonably good. She had some insight into her condition. Her intelligence was of low average.

Progress. For the first month after admission she remained in the same depressed state with no interest in anything. Dexidrene given in increasing doses produced no change. She had no further attacks of migraine and her E.E.G. was within normal limits. She was then given six E.C.T. and improved steadily. Her marital problems were discussed with her but she did not regard them with any great seriousness once her depression was better. She was referred to a Birth Control Clinic, advised against further childbirth, and discharged on 20. 11. 48. She subsequently attend the Follow-up Clinic and has remained very well and in fact took charge of her sister's children when she (M.A) was admitted to hospital this year.

Diagnosis. Depression occurring two months after the birth of a second child in a woman with two previous depressive illnesses and a strongly positive family history of mental disorder.

Case 24. N.C. Aged 40. Multipara. Admitted 13.3. 49.
Home address - North West London.

Reason for Referral. Suspicious and frightened immediately following the birth of a second child in September 1948.

Family History. The family was a well-to-do Dutch one living in the Hague. The father was a business man who suffered from violent tempers and died during the German occupation of Holland. The mother developed disseminated sclerosis when the patient was seven and died when the patient was twenty. Following the mother's death the father remarried and the patient became ill and attempted to poison herself. The patient's home life was an unhappy one, with violent quarrels between the parents. There was one brother, six years younger than the patient. He developed an obsessional neurosis, was analysed by Stekel in Vienna, subsequently married and then shortly afterwards committed suicide. He too, like the father, was subject to violent outbursts of temper, during which on several occasions he attacked the patient. There was no other family history of mental disorder.

Personal History. As a child, the patient was enuretic. She was sent to the best school in the Hague where she did well and subsequently went on to Leiden University and studied law. She qualified as a Lawyer, then turned journalist, writing articles for a Dutch Communist paper. As a student she had an intense homosexual affair, and several others subsequently. When she was twenty and following her breakdown she too was analysed by Stekel, and subsequently started to have heterosexual relationships, all of which were unhappy. She came to England and it was here she met her husband. He was six years younger than the patient, had fractured his spine some years previously and was lame. He too was a Communist and editor of a Communist weekly paper. They lived together for a time and finally married. At first the marriage was satisfactory and in 1942 she had a son. The first year after his birth she was very happy and at the end of that time they moved into a house with another married couple they knew. When the raids became bad in London she and the other wife went to Bedford but at the same time the patient was trying to look after her son and run a job with the Dutch Government in London as well. In the summer of 1947 the husband, who had always been neurotic, had some sort of nervous breakdown, was unable to concentrate, and gave up working so that the patient had to support him from her own private means. This breakdown lasted 18 months and he has only worked spasmodically since. During his breakdown they practised "mutual self-analysis" after reading Karen Harney's books. They continued this till January 1948 and in the process the patient discovered that he was in love with the other woman with whom they lived. In December 1948 the patient became pregnant and was shortly afterwards invited by a woman friend to spend a year in America. Although the husband was unable to make a decision between the two women he resented his wife's idea of going away and there were frequent violent quarrels between them. In the Spring of 1948 the patient invited the other woman to accompany them on their holiday and it was at this time that the husband first started having intercourse with her although at that time unknown to the patient. Shortly afterwards the patient went on her annual holiday to Holland, leaving her husband to look after their son.

Previous Personality. She was an atheist, also an emotional and moody woman who resented her inability to obtain maids and having to do all her own housework, feeling that her husband did not do his share of the work. She was always an active and ambitious woman, read widely and was interested in classical music which her husband detested. She was particularly attached to her son and liked family life.

History of Present Illness. Following her return from Holland and towards the end of her pregnancy, she developed toxæmia and was told there was a possibility of a Caesarian section being done. This frightened her very much but proved to be unnecessary. The pregnancy was terminated ten days before term and she had a normal straightforward delivery of a girl on 19. 9. 49. Following this she complained that she could not focus her eyes properly, was extremely suspicious and frightened, believing that everyone was against her and was keeping her in the dark. She thought that there was a war on, that the newspapers were being specially printed in the hospital to deceive her, and that she was going to be bombed. She seemed to recover more or less and came home three weeks later and was able to breast feed the baby. In spite of her apparent recovery she was not quite her normal self and seemed rather vague and suspicious at times. In December 1949 her husband told her that he was now having intercourse with the other woman. There were further rows after that and the atmosphere became more strained, but still the husband refused to make a decision and resented his wife's suggestion that she should go to her friend in America. A week before admission, this all came to a head and the patient became extremely angry. Three days before admission she demanded intercourse, then refused, asked again and finally went cold at the climax, and her husband told her that he would not share her room any more. After that she began to talk irrationally, said she wanted to micturate and defæcate in bed, that she loved everyone in the house, and that she was afraid of death. She thought the lavatory was blocked and she likewise. She showed intense fear of her husband but also attacked him and then ran from the house. She was brought back and seemed preoccupied with her family, saying that it was diseased, also that Holland was a diseased country. She was seen by a psychiatrist who felt that her talk was often irrelevant and beside the point, and she told him that there was something wrong with her for her labour to have had to be induced. She was admitted to hospital as an emergency that day.

State on Admission. Physically, there was no abnormality and she was still lactating. Mentally, she seemed very suspicious, perplexed and retarded. She refused to answer questions, appeared hallucinated and stated that she was afraid of death or of going mad and that she thought the food was poisoned. She was incontinent of urine and faeces.

Progress. Ten days after admission she attempted to commit suicide. There was evidence of depression, but suspicion still predominated and she complained that someone was putting thoughts into her head by electricity and that they were influencing her eyesight. She said that from the time the baby was born she felt her mind was torn apart and heard voices calling her

name. She often seemed confused and asked whether she were Mrs. or Miss C. and that there were many Mrs. C's. She was worried and anxious about her children and thought that the baby might be dead. She was given E.C.T. and responded well to it. Meantime her husband disappeared and the patient discharged herself against advice five weeks after admission. She was subsequently seen once in the Out-patient Department by which time she had contacted her husband but still seemed mildly depressed.

Diagnosis. A mixed schizo-affective illness following childbirth and associated with a difficult marital situation.

Case 25. F.H. Aged 45. Multipara. Admitted 18. 8. 49.
Home address - South East London.

Reason for Referral. Unable to remain in the house alone or cope with household duties, owing to fear and loneliness associated with depression and following the birth of a stillborn child in April 1949.

Family History. The father, who had been previously married and had a son and daughter by that marriage, was an engineer. He was rather strict and at times drank heavily, so that the patient was afraid of him. He had a stroke early in the patient's life and was unable to work following it, so that the mother had to go out to work, and the father looked after the children, none too adequately, so that meals were often poor and scanty. The patient slept in her parents' room and at a very early age witnessed parental intercourse, identified herself with the mother, and resented the father's behaviour. Later when she was about four or five her father attempted to seduce her. The father finally died from a stroke in 1926. The mother was a quiet, self-effacing person to whom the patient was very attached, and on whom she was over-dependent all her life. The patient was the youngest of the children, having one full brother who was always considered to be "nervous" and whose marriage has not been successful. The step-siblings appear to have been more stable than the patient and her brother but were looked down upon by the patient as being less intelligent and well-educated. The maternal grandfather drank heavily and left the maternal grandmother, who then lived with another man for many years and ultimately married him when she was 70. There is no family history of mental illness. On the whole, the home circumstances were reasonably happy and the parents got on well together.

Personal History. The patient's early development was normal and she had no neurotic traits in childhood. She did well at school and was head girl. She won a scholarship, which she was unable to take up owing to poor financial circumstances at home, and left at fourteen. Her periods started when she was eleven, and although the onset was not traumatic, she was always rather upset during menses, suffered from headaches and refused to carry on her usual activities. She always considered menstruation as highly unpleasant, rather resented having periods and considered all her life that men were much more fortunate. After leaving school she had numerous jobs as typist and comptometer operator. She started having minor affairs with boys when she was twelve. At the age of sixteen she met her first serious boy-friend. He was the same age as herself and the affair continued on the basis of friendship with some love-making until they were twenty when they started to have intercourse. She herself wanted it but she also felt it would help in keeping her boy-friend. He developed a tuberculous infection of one knee and had to have the leg amputated. The patient wanted to leave him when he came out of hospital because of his deformity but remained with him, while at the same time having an affair with her employer, a married man much older than herself. About this time her father died and she developed an anxiety neurosis with headaches, aching pain in one arm, dryness of the mouth and jerky movements, and was admitted to hospital in September 1927. She was discharged somewhat improved a month later. She returned home and still unable to reach a decision about her boy-friend, who wanted to marry her, or about her employer, she again broke down in March 1928 with feelings of impending death and inability to breathe properly. This time she remained in hospital for nine months, leaving in November 1928. She took another job for six months after leaving hospital and then returned to the invalid role of being unable to get out alone and having constant headaches. The affair with the man with the T.B. leg continued, but in 1932 she met her husband. Still unable to make any decision, she would see him secretly until he demanded a decision should be reached by the patient as to which man she wanted. Her husband handled the situation and the patient was very irritated to find that her other boy-friend had someone else and was quite pleased to leave her. He ultimately married another woman and it was with a sense of satisfaction that the patient saw the marriage turn out a failure. She remained an invalid until her fiance got sick of it and told her if she didn't get better he would leave her and so they became engaged. She broke down again and attended hospital as an out-patient in March 1936.

She was afraid of marriage and more so of childbirth, even though her fiance had assured her that she need have no children. She attended hospital for five months, complaining of fears of falling, and then with the help of a dog her fiance had given her, she started to go out alone. They had pre-marital intercourse which was satisfactory to the patient and she gradually improved until in 1938 they married. The patient's husband was seven years younger than herself, a stable personality, and a clerical officer at the M.O.W. In 1939 she became pregnant and again appeared as an Out-patient with anxiety symptoms. She had no desire to have a child, resented the fact that she was pregnant, and considered that a man's life was far easier than a woman's. She miscarried a few weeks later and was greatly relieved. In 1940 she again became pregnant, but hardly had time to develop anxiety symptoms before she again had a miscarriage. In September 1940 the patient and her mother left London to avoid the raids and her husband remained alone in the flat until his call-up in May 1941. She saw her husband intermittently till November 1942 when he was sent abroad and remained away until October 1945. During those three years the patient lived happily with her mother in Salisbury, entertained the troops and did canteen work. After her husband's return they lived with the patient's in-laws until June 1946. The patient did not get on with her mother-in-law and was most unhappy till they found a flat of their own and moved. In 1947 she again missed a period, thought she was pregnant, started to develop anxiety symptoms which disappeared when she started menstruating normally a month later. She became pregnant again about September 1948, and at first feared she was going to die but partly due to criticism from her in-laws and partly because she felt she was getting near the end of her childbearing period, she decided to let the pregnancy go on. At four months she had a haemorrhage and at six months felt no movements. She felt sure the child was dead but was not much upset by this. Feeling now that honour was satisfied, she was anxious only to get rid of the child. At the seventh month of pregnancy in April 1949 she had a labour lasting several hours and the child was stillborn. She had several bouts of crying while in hospital but seemed alright on discharge. It was ascertained at this time that she and her husband had an Rh. incompatibility.

Previous Personality. She has always been over-attached to her mother, but apart from her preferred men's company to woman's and had few close friends of her own. Normally an attractive cheerful person, who mixed easily with others she would strike up conversations with perfect strangers. In household affairs she was capable, careful in money matters and always got what she wanted from shop-keepers, refusing to take "no" for an answer. Although much interested in herself she was unselfish and went out of her way to help others. She was energetic but only within her own carefully set limits, and always underestimated her own capabilities. She was always anxious and worried about other people's opinion of her.

History Present Illness. Following the still-birth in April 1949, she went to stay with her in-laws and whilst there the dog, given to her by her husband in 1936, had to be destroyed. She immediately became rather depressed, said she had no strength or energy, and that there was no future. She gradually developed fears of falling in the street and unpleasant feelings in the neck. She became unable to eat or sleep, had difficulty in thinking, and paraesthesiae of her legs. She became afraid of being alone, would spend all day with relatives and was quite unable to cope in her own house. She was afraid to go out alone and tried to stop her husband from going to work, threatening to throw herself downstairs. She was seen at the Out-patient Department on '8. 7. 49, begging to be admitted, but refusing admission to another hospital when she knew there was no vacancy at the time. She became more depressed however, thought her husband wanted to leave her, spent all day with her mother and could do nothing in the house and was finally admitted to hospital on 18. 8. 49.

State on Admission. Physically. There was no abnormality. Mentally. She was mildly depressed, extremely anxious, tense and histrionic. She complained of an unknown fear and was afraid to be alone by day or night. She constantly demanded reassurance but was unable to accept it. She was correctly orientated, Attention, concentration, and memory were quite good and she was of average intelligence.

Progress. During her time in hospital she had systematic psycho-therapy during which her resentment of her feminine role became more apparent, her dislike and fear of pregnancy seemed linked to this and she greatly resented the distortion of her body by pregnancy. She was afraid of further intercourse owing to her fear of becoming pregnant again but at the same time afraid that she might lose her husband because of her refusals especially as he was so much younger than herself. She was referred to a Birth Control Clinic, but disliked the idea of contraception for herself.

She was given week-ends of increasing length at home and her anxiety would return with renewed force at first after these, but with explanation and reassurance she gradually made an adjustment and was discharged on 6. 12. 49. She was asked to attend the supportive clinic but after one visit said she was getting on satisfactorily and preferred not to come any more.

Diagnosis. .An anxiety state with mild depressive features following childbirth in an unstable personality.
